

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LULA MOBLEY

2. DATE AND HOUR PRONOUNCED

April 18, 1966

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

LUTHERAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before death)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2127 Braddish Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

WIDOW

8. DATE OF BIRTH

Jan 8 - 1902

9. AGE (In years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

York Co. S.C.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Jim Tate

14. MOTHER'S MAIDEN NAME

Mary Lucas

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

HENRY FASTER 805 N BENTLEY ST

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) _____
DUE TO

Arteriosclerotic heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT ☐
m. WORKNOT WHILE ☐
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-19-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

APR 20 1966

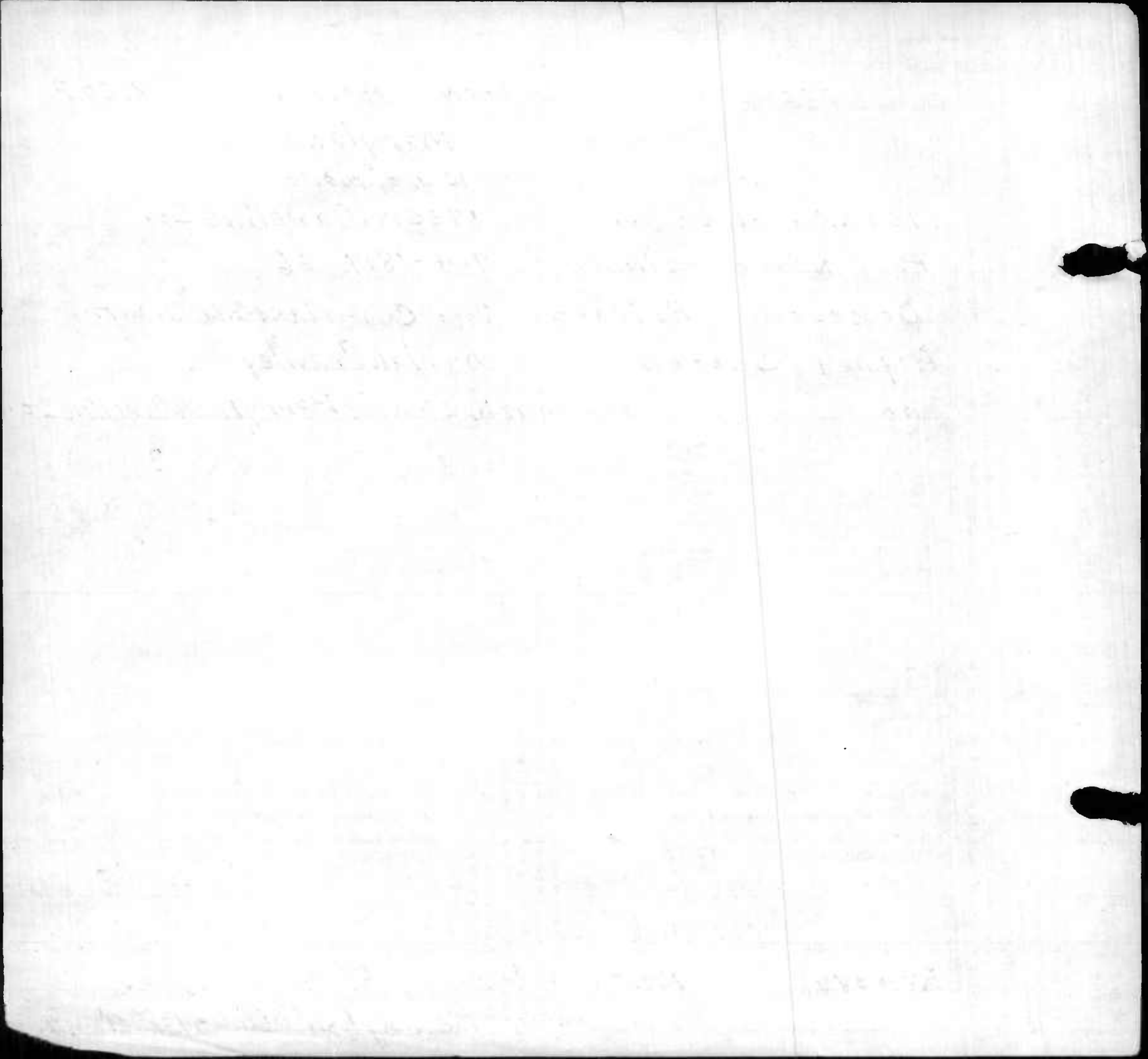
VALLEY FORGE

PAID

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04002	
BIRTH NO. 66 04002		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Rebecca Sutton</i>		2. DATE AND HOUR OF DEATH <i>4-15-66 8:30 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>8-06</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>80</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
D. STREET ADDRESS (If rural, give location) <i>1735 N. Caroline St.</i>					
5. SEX <i>F.</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>SINGLE</i>	8. DATE OF BIRTH <i>7-4-1899</i>	9. AGE (In years last birthday) <i>66</i>	If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Private</i>		11. BIRTHPLACE (State or foreign country) <i>Northumberland Co. Va. U.S.A.</i>	
13. FATHER'S NAME <i>Alfred Sutton</i>		14. MOTHER'S MAIDEN NAME <i>Mariab Crawley</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>820-30-1118</i>		17. INFORMANT <i>Mrs Marie Barry</i>	
				ADDRESS <i>1735 N. Caroline St.</i>	
18. <i>433.11</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>mesenteric thrombosis</i> DUE TO		<i>3 Days</i>	
ANTECEDENT CAUSES		(B) <i>Auricular Fibrillation</i> DUE TO		<i>3 Days</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <i>Arterio Sclerosis</i>		<i>?</i>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1-15-1966</i> to <i>1-15-1966</i> , that (I) (we) last saw the deceased alive on <i>1-15-1966</i> and that in (my) (foot) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Eugene H. Owens</i> M.D.				23B. DATE SIGNED <i>4-18-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Eugene H. Owens</i> M.D.				23D. ADDRESS <i>1735 E. Federal St.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <i>Not Olive Cemetery Kilnashock, Va.</i>	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR <i>APR 20 1966 R.E. Jones</i>	
24G. NAME OF REGISTRAR		24H. FUNERAL DIRECTOR <i>Randolph J. Collick</i>		24I. ADDRESS <i>243 E. Olives St.</i>	



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Aljay Laboard

2. DATE AND HOUR PRONOUNCED DEAD

4/17/66 9:50 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

620 N. Fremont Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

2-28-1918

9. AGE (in years last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

NONE

11. BIRTHPLACE (State or foreign country)

S C

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

BRADY LABORAD

14. MOTHER'S MAIDEN NAME

MARIE BRADY

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

YES 10-29-43 + 12-22-44

16. SOCIAL SECURITY NO.

214-14-4069

17. INFORMANT

JAMES LABOARD 620 N. FREMONT AVE

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Gunshot wound of abdomen, involving stomach, liver, small intestine and right side of diaphragm with right sided hemothorax

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

620 N. Fremont Ave.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

4 17 66 12:30 a.m.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

shot several times

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/18/66

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

4-21-66

23C. NAME OF CEMETERY or CREMATORY

BALTIMORE NATIONAL

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE Md.

24A. DATE REC'D BY HEALTH DEPT.

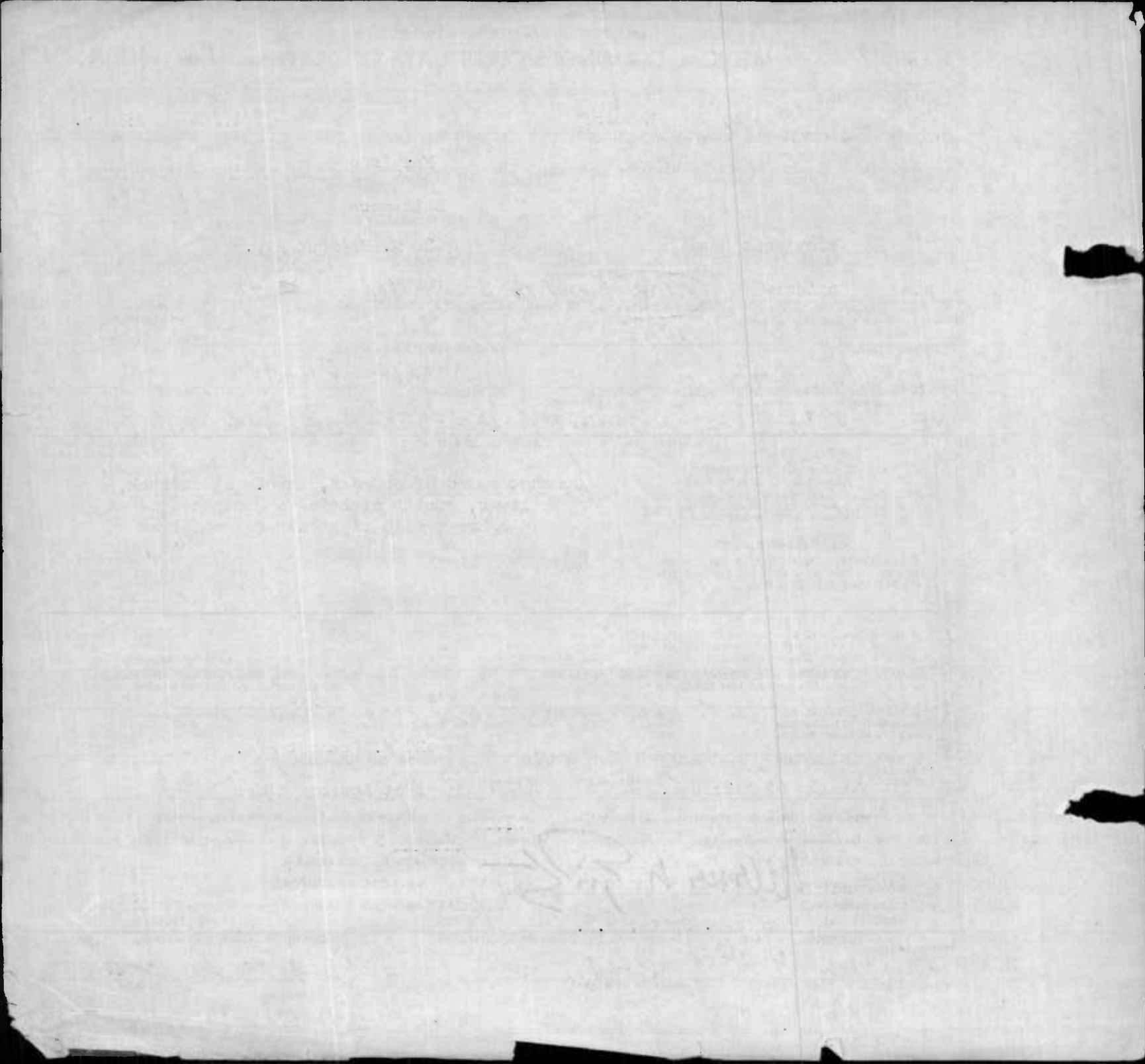
APR 20 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JOSEPH KNIGHT 1639 N. BROADWAY



1
L-163

66 04004

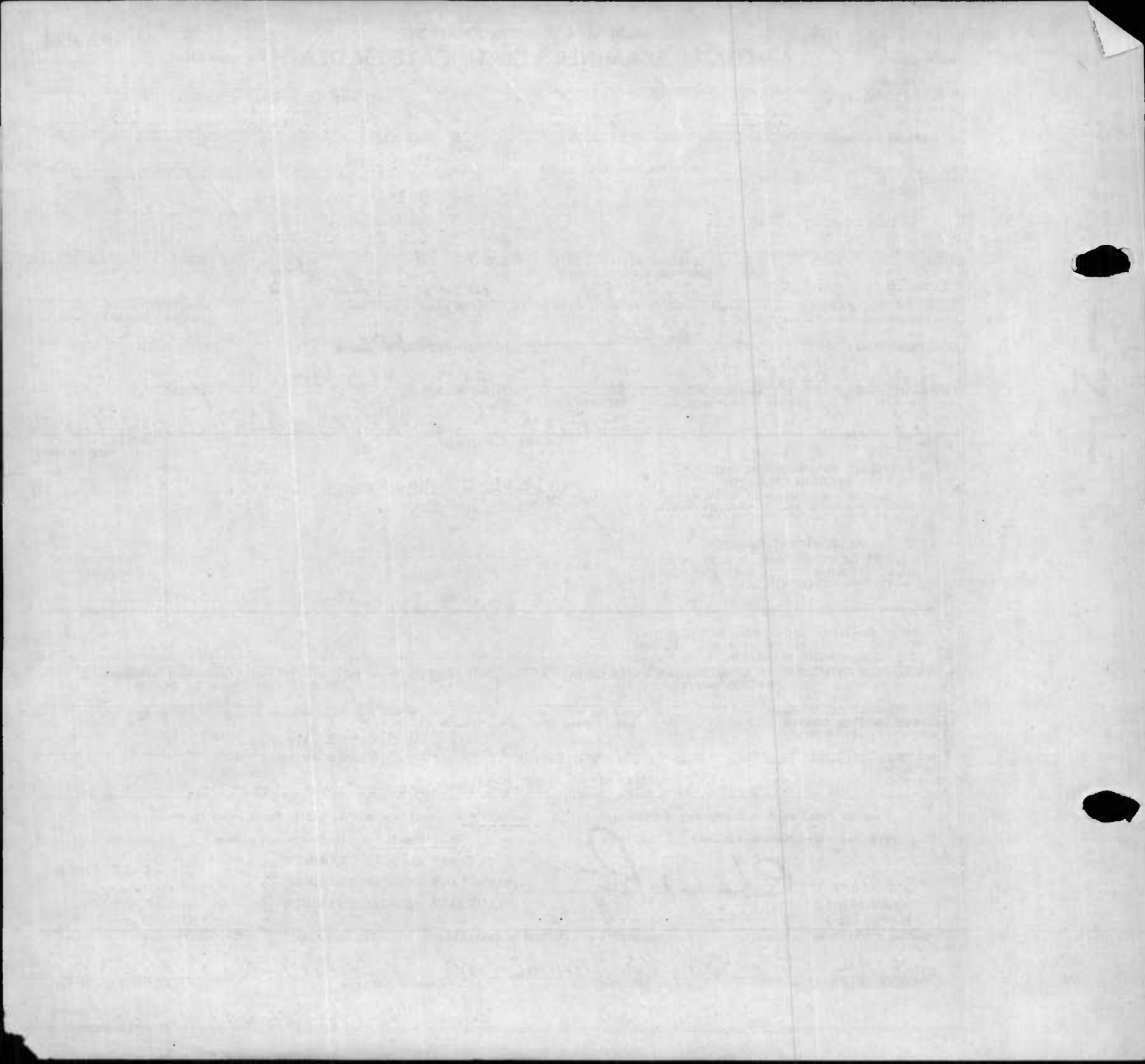
BALTIMORE CITY HEALTH DEPARTMENT

66 04004

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD			
LUCILLE LaBOARD				April 17, 1966 12:40 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital				A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 620 Fremont Avenue			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-25-1922	9. AGE (In years last birthday) 44	10. Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AMOS LOCKLEY				14. MOTHER'S MAIDEN NAME EVA NORMAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 225-18-4245		17. INFORMANT ADDRESS JAMES LABOARD 620 N. FREMONT AVE.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Gunshot Wounds of Head, Neck and Trunk. INTERVAL BETWEEN ONSET AND DEATH							
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST, (B) DUE TO (C)							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 620 Fremont Avenue			
21D. TIME OF INJURY (APPROX.) 4 17 '66 A M.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Shot during altercation.			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/17/66	
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE 4-21-66		23C. NAME of CEMETERY or CREMATORY BALTIMORE MD		23D. LOCATION (City, town, or county) (State) BALTIMORE NATIONAL	
24A. DATE REC'D BY HEALTH DEPT. APR 20 1966		24B. NAME OF REGISTRAR J. Knight		24C. FUNERAL DIRECTOR JOSEPH KNIGHT		ADDRESS 1639 N BROADWAY	

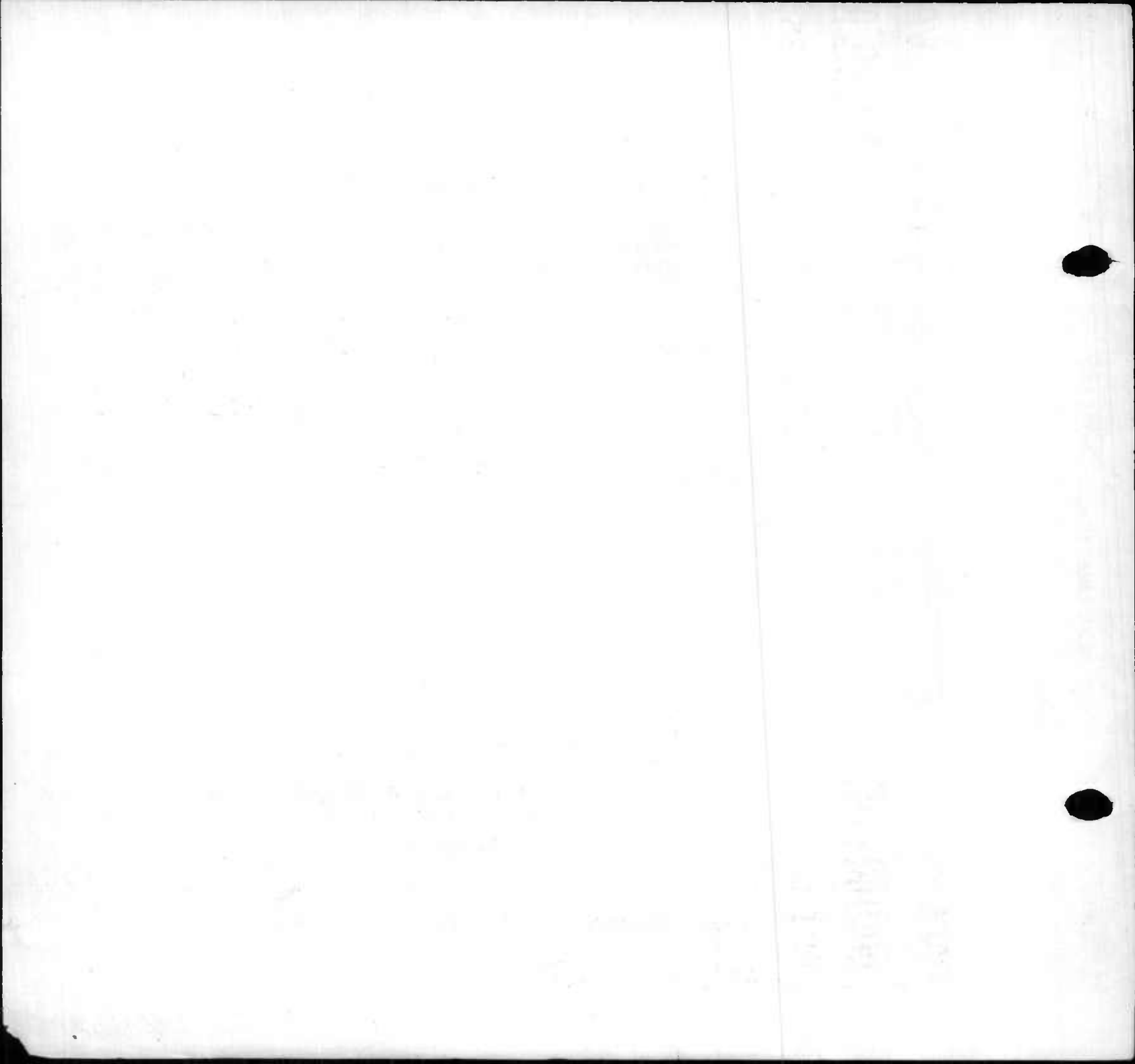
N 903-4



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66-04005	
BIRTH NO. 62-32198 66 04005		CERTIFICATE OF DEATH		Registered No. 66-04005	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Bowman, Clarence		April 17, 1966 11:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
The Johns Hopkins Hospital		Md Baltimore		7-04	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		1813 E. Chase St			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
male	N	never married	Nov/25/61	54	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
child		None		Baltimore	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
United States		Robert Bowman		Jeannette Salley	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				ROBERT BOWMAN 1813 E. CHASE ST.	
18. 1939 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Medulloblastoma		1 year	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO			
ANTECEDENT CAUSES		(C) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7 PM April 16 1966 to April 17 1966 that (I) (we) last saw the deceased alive on 11:30 AM April 17 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Shi-Shung Huang M.D.		April 17, 1966			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
SHI-SHUNG HUANG M.D.		The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	1 State	
Burial	4-20-66	MT CALVARY	a.a. COUNTY Md.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS		
APR 20 1966	R. E. S. Jr.	JOSEPH KNIGHT	1639 N BROADWAY		



66 04006

BALTIMORE CITY HEALTH DEPARTMENT

66 04006

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN

E.

COWAN

2. DATE AND HOUR PRONOUNCED DEAD

April 17, 1966

8:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

6542 St. Helena

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6542 St. Helena

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

April 16- 1904

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Engineer,

Patapsco

10B. KIND OF BUSINESS OR INDUSTRY

Back River Railroad

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Calvin Cowan

14. MOTHER'S MAIDEN NAME

Hulda Vaughn

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL
SECURITY NO.

705-10-9429

17. INFORMANT

ADDRESS

Wife, Mrs. Mable Cowan, # 4, a, b, c, d.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/17/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial.

23B. DATE

April 21-1966

23C. NAME of CEMETERY or CREMATORY

Bush Creek Cemetery

23D. LOCATION

(City, town, or county)

Irwin, Pennsylvania

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 20 1966

24B. NAME OF REGISTRAR

Robert E. Selby, M.D.

24C. FUNERAL DIRECTOR

JOHN J. DUDA, Dundalk, Maryland 21222

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT C-6201 66 04007 CERTIFICATE OF DEATH				Registered No. 66 04007	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) STANLEY M. CRAIG, SR.		APRIL 17, 1966 8:10 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & HOSPITAL			A. STATE MARYLAND B. COUNTY 26-36		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 6546 St. Helena Ave. # 22		
5. SEX M	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11/30/95	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME JOHN MORRELL			14. MOTHER'S MAIDEN NAME MONA GREGG		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213077989	17. INFORMANT ADDRESS HOSPITAL RECORDS		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction			INTERVAL BETWEEN ONSET AND DEATH 4 hrs		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 4/12 19 66 to 4/17 19 66 , that (I) (we) lost saw the deceased alive on 4/17 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Manuel J. Tan			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) MANUEL J. TAN			23D. ADDRESS CHURCH HOME & HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 4/21/66	24C. NAME of CEMETERY or CREMATORY OAK LAWN	24D. LOCATION (City, town, or county) (State) BALTIMORE, MD		
25A. DATE REC'D BY HEALTH DEPT. APR 20 1966		25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR ADDRESS Walter Burke Barclay, Realtor, Md.		

JOHN MORSE

RETIRED

M WHITE MARRIED

WIRLAND

MONA GREGG

DISCHARGED

And information

4/13

4/13

MANUEL J TAN

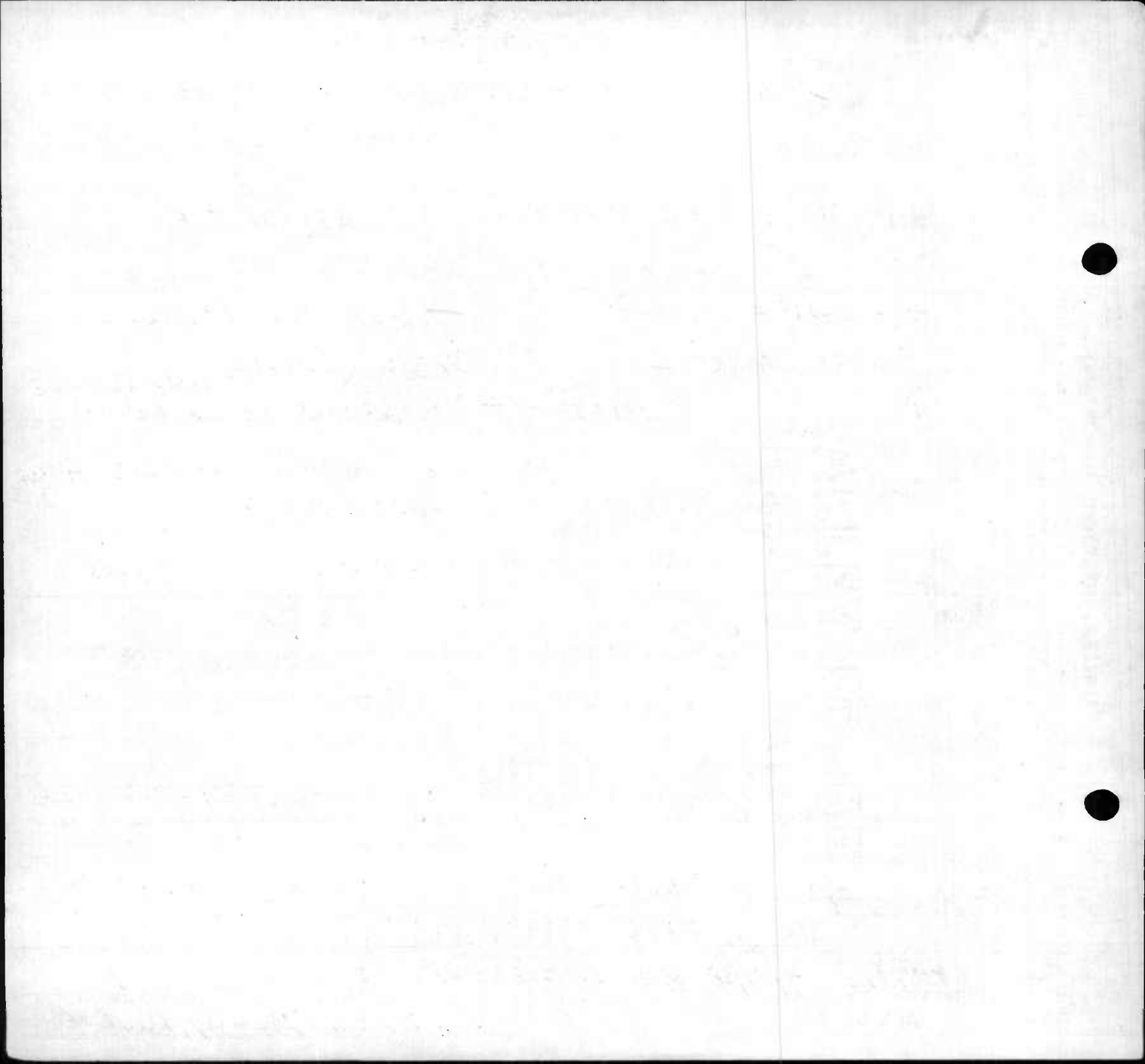
CHURCH HOME & HOSPITAL

X

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

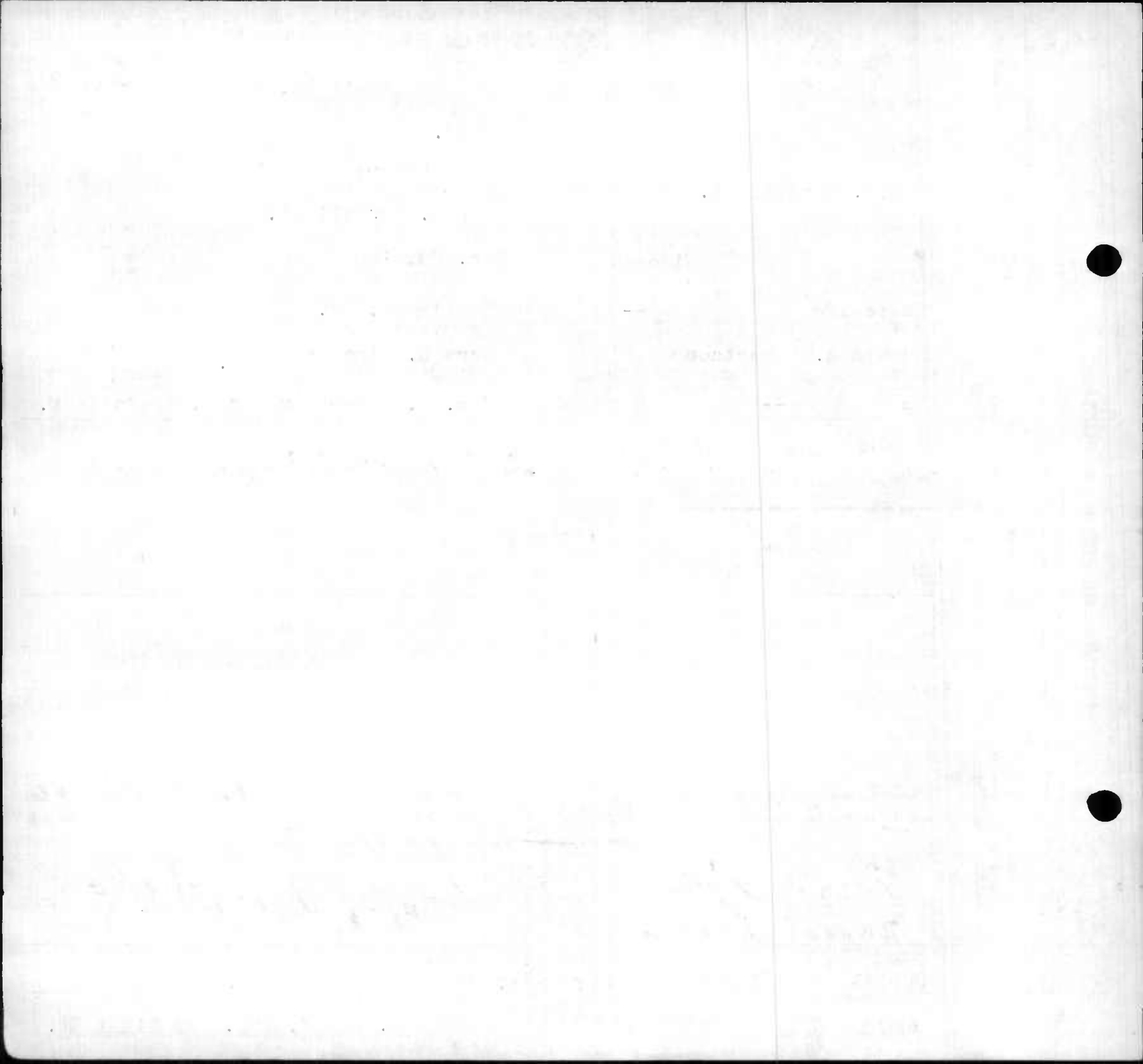
BIRTH NO. 66 04008				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 04008	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				LANGE MRS. ANNA COTTRELL		4-17-1966 12:35 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. STATE			
				FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND			
				CITY OR TOWN (If outside city limits, write RURAL and give township)		DUNDALK 22			
				D. STREET ADDRESS (If rural, give location)		1947 - WALNUT AVE.			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
F		W		WIDOWED		DEC 22 1892		73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE				—		AT CARDWELL, VA.		U.S.A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
STUART COTTRELL				DANIE BOWLES		NO			
16. SOCIAL SECURITY NO.				17. INFORMANT		18. CAUSE OF DEATH			
212521565				MRSCAROLINE L. STACHEVICH		INTERVAL BETWEEN ONSET AND DEATH			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) DUE TO		MULTIPLE CEREBRAL THROMBOSIS 4 MONTHS			
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				(B) DUE TO		I QUADRIPLÉGIA			
ANTECEDENT CAUSES				(C) DUE TO		A.S.H.C.U.D. YEARS			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0				NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 3-16-1966 to 4-17-1966.				that (I) (we) last saw the deceased alive on 4-17-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED			
ZIN U. PARK						4-17-1966			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
ZIN U. PARK				M.D. MONTEBELLO STATE HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
BURIAL		4/20/66		BALTO. NATIONAL		BALTIMORE, MD			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
APR 20 1966		Robert E. J. J. J.		Walter Andrew Pundley, Dundalk.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

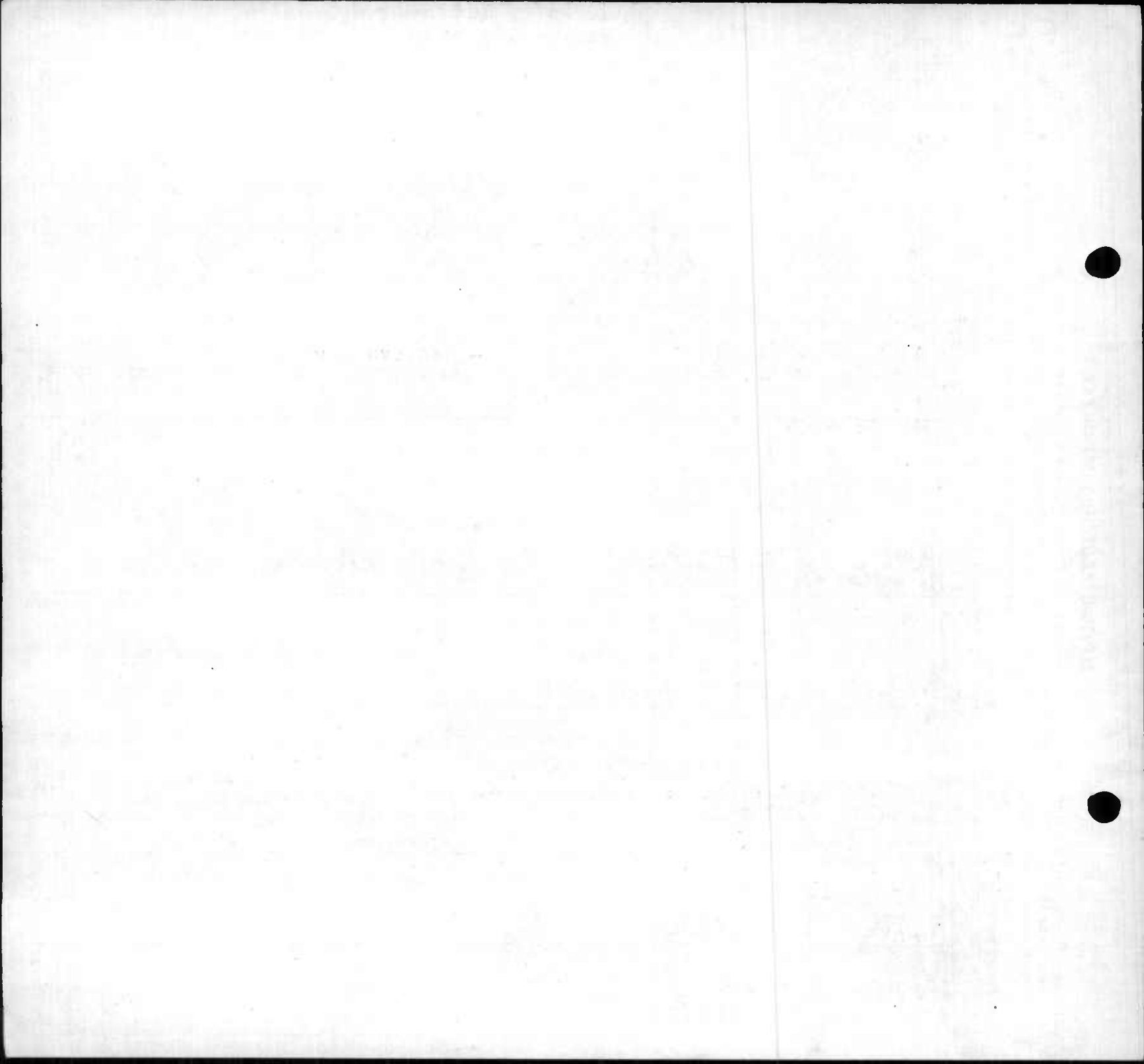
BIRTH NO. 66 04009				BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 66 04009	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ETHEL MARIE BURNS				2. DATE AND HOUR OF DEATH April 15, 1966 4:25 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3 W. Randall St.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2302 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3 W. Randall St.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Dec. 28, '20	9. AGE (In years last birthday) 45	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edward A. Robertson				14. MOTHER'S MAIDEN NAME Cora L. Wiganne			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --		16. SOCIAL SECURITY NO. --		17. INFORMANT Jos. E. Robertson		ADDRESS 3 W. Randall St.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1965 to April 14 1966 , that (I) (we) last saw the deceased alive on April 14 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Ricardo Lopez				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/18/66	
23C. PHYSICIAN'S NAME (Type) RICARDO LOPEZ				23D. ADDRESS 1225 S. Charles St. Balto. 30, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/19/66		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1966		25B. NAME OF REGISTRAR R. E. Farber		25C. FUNERAL DIRECTOR JOHN F. DENNY, INC.		ADDRESS 715 Light St.	



FUNERAL DIRECTOR: IMPORTANT

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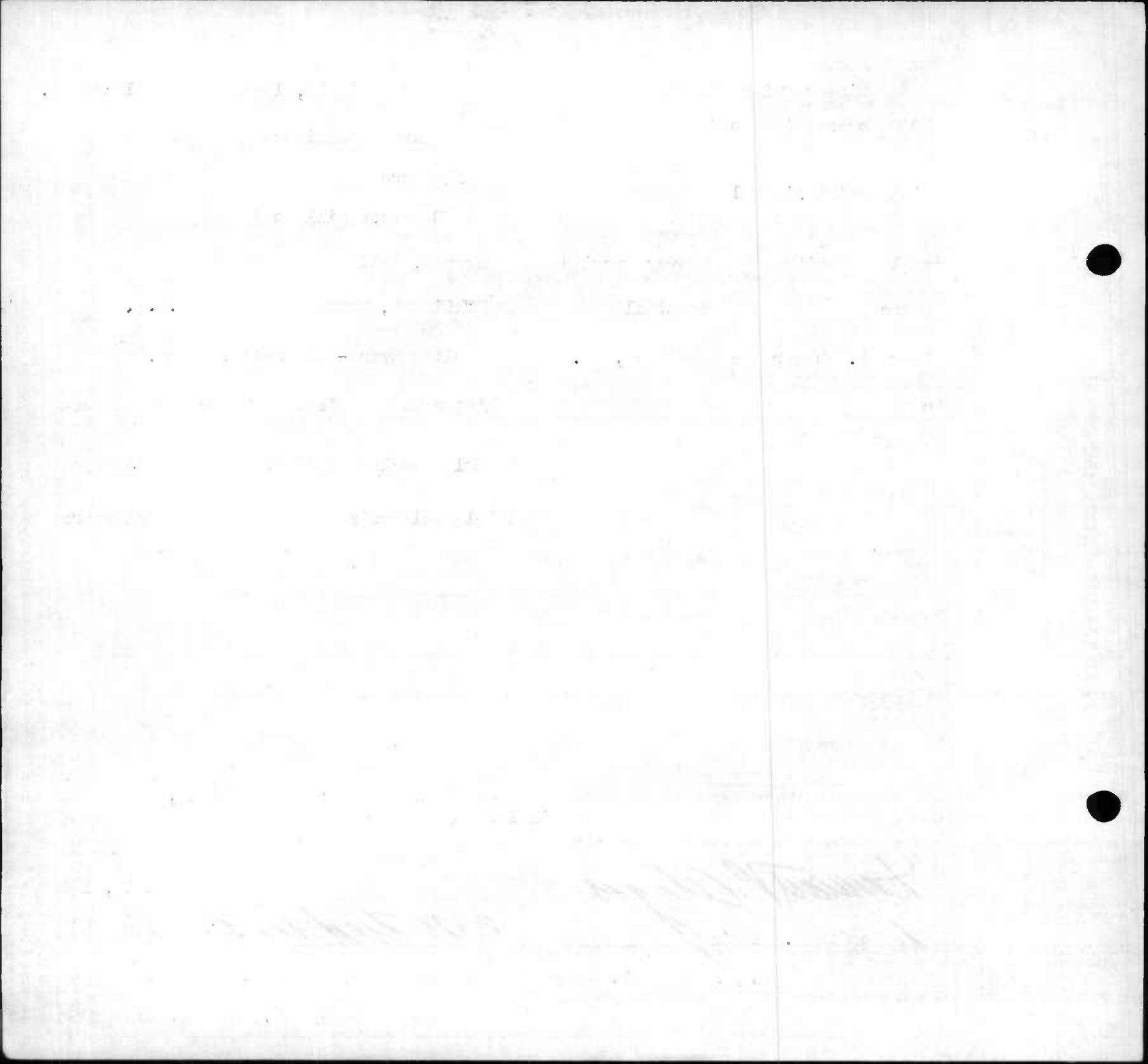
BIRTH NO. 66-04979 66 04010		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 86 04010	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CAROLYN DEE PROUD		2. DATE AND HOUR OF DEATH 4/17/66 6:10 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY BALTIMORE			
5. FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL BALTIMORE, MD.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 1145 WASHINGTON BLVD.	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) INFANT	8. DATE OF BIRTH 3/8/66	9. AGE (In years last birthday) 1	If Under 1 Yr. Months: 9 Days: 9 Hours: 10 Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) BALTIMORE	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME NELSON PROUD		14. MOTHER'S MAIDEN NAME A MARILYN OBWALD	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT Mr Nelson Proud ADDRESS above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 754.71 Respiratory arrest/pulmonary hemorrhage Thrombosis of Cerebral artery Myocardial infarction		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 1 hr ? 3 wks birth	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 3/8/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BANDING PULM. ARTERY		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/14 19 66 to 4/17 19 66 , that (I) (we) last saw the deceased alive on 4/17 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE W Coussons		23B. DATE SIGNED 4/17/66	
23C. PHYSICIAN'S NAME (Type) HARRIET W. COUSSONS		23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/19/66		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cem.	
24D. LOCATION (City, town, or county) Borsey		24E. NAME OF REGISTRAR John J. Cowan & Sons Inc.		24F. FUNERAL DIRECTOR John J. Cowan & Sons Inc.	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1966		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. ADDRESS 901 St. Hollins	



FUNERAL DIRECTOR: IMPORTANT

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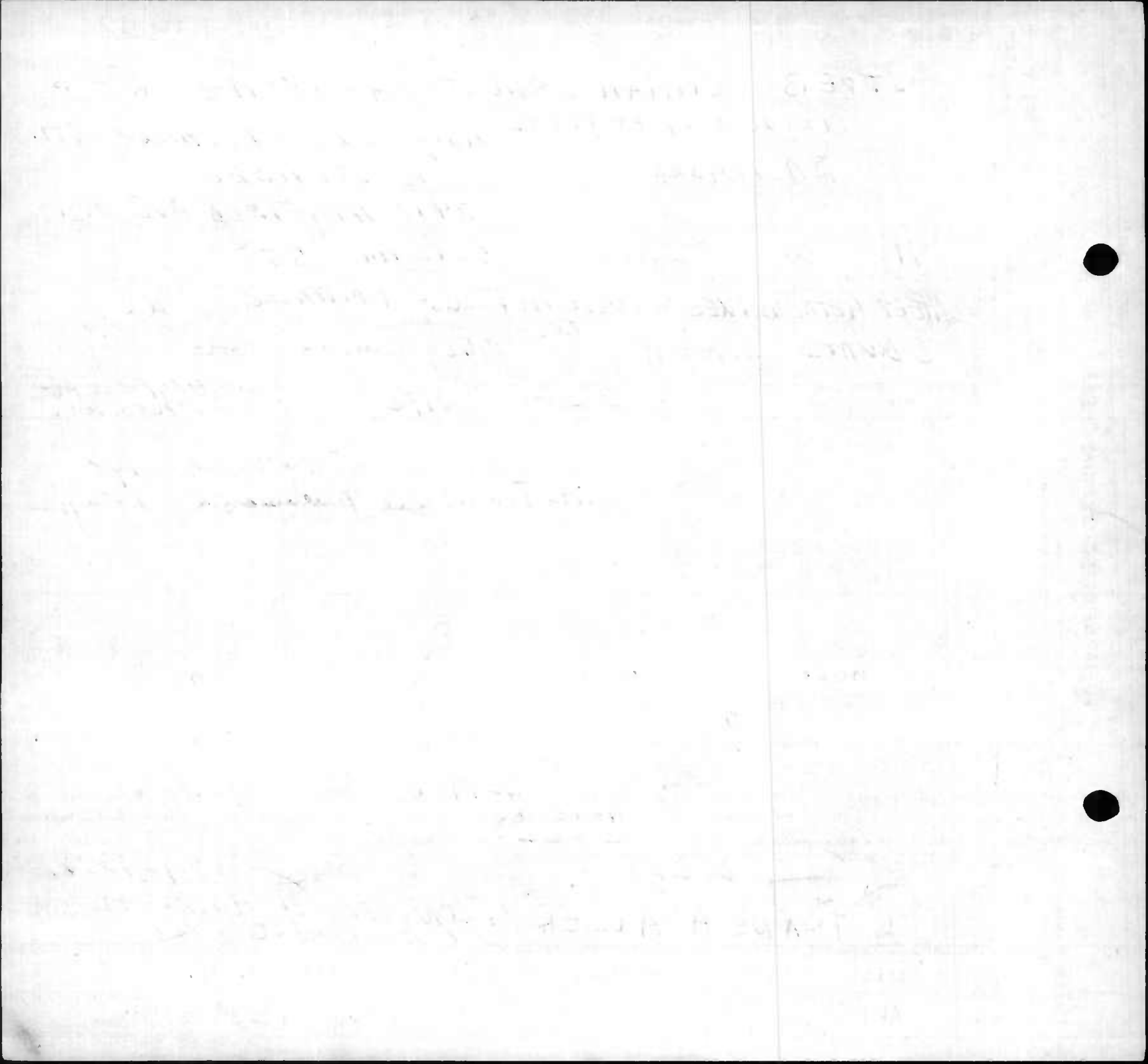
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 86 04011	
BIRTH NO.		66 04011		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Sister Emily Thoman		April 19, 1966 12:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
4000 Forest Hill Road FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland Baltimore		28-41	
Villa Saint Michael		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		4000 Forest Hill Road	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Female	White	Never married	March 6, 1912	54	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Nurse		Hospital		Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Henry A. Thoman - Baltimore, Md.			Pauline Eyth - Pittsburg, Penna.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Sister Mary Louise, 4000 Forest Hill Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
331 XI		(A) Cerebral vascular accident		3 days	
ANTECEDENT CAUSES		(B) Multiple Sclerosis		21 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) the physician attended the deceased from June 21, 1959 to April 18, 1966, that (I) we last saw the deceased alive on April 18, 1966 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we did not (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<i>Damian P. Alagia</i>				April 19, 1966	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Damian P. Alagia		3376 Frederick Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		Apr. 21, 1966		St. Joseph's Cemetery	
				Emmitsburg, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 20 1966		Robert E. Fairbank		Stewart & Mowen Co., 108 W. North Av., City	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
66 04012 CERTIFICATE OF DEATH					Registered No. 66 04012				
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				STREB, WILLIAM ERNEST		4-18-1966 6:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
UNIVERSITY HOSPITAL					A. STATE: Maryland				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					B. COUNTY: BALTIMORE CITY				
BALTIMORE					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					BALTIMORE 26-03				
D. STREET ADDRESS (If rural, give location)					3413 HAYFIELD AVE. 21213				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
M.	W	married		2-1-1911	55				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
SHEET METALWORKER for JOGLESIDE Plumbing				BALTIMORE CO.		BALTIMORE		U.S.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
EDWARD STREB					Wilhelmina Hertz				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			
no				213-05-4771		WIFE 3413 HAYFIELD AVE BALTO. MD.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO				
ANTECEDENT CAUSES					Cancer of the Lung 1 yr with Terminal pneumonia 2 days -				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO				
					O				
					(C)				
II					5				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
none		none		NO		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
no									
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 4-17-66 19 to 4-18-66 19, that (I) (we) last saw the deceased alive on 4-18-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED	
Dr. Franz A. Adler								4-18-66	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
Dr. FRANZ A. ADLER					UNIVERSITY HOSPITAL BALTIMORE MD.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		4/22/66		Oak Lawn Cemetery		Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			ADDRESS		
APR 20 1966		Robert E. Finkler, MD		Schimunek Funeral Home, Inc.			3331 Brehms Lane		



66 04013

BALTIMORE CITY HEALTH DEPARTMENT

66 04013

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Anthony Picek

2. DATE AND HOUR PRONOUNCED DEAD

4/17/66 5:30 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3600 Frankford Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married

8. DATE OF BIRTH

8/16/1900

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Butcher

10B. KIND OF BUSINESS OR INDUSTRY

Esskay

11. BIRTHPLACE (State or foreign country)

Czechoslovakia

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

James Picek

14. MOTHER'S MAIDEN NAME

Anna Laznowska

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Barbara Tesar Picek, wife, above

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Arteriosclerotic and hypertensive cardio-
DUE TO vascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/18/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/20/66

23C. NAME of CEMETERY or CREMATORY

Moreland Mem. Park

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 20 1966

P. E. E. E. E.

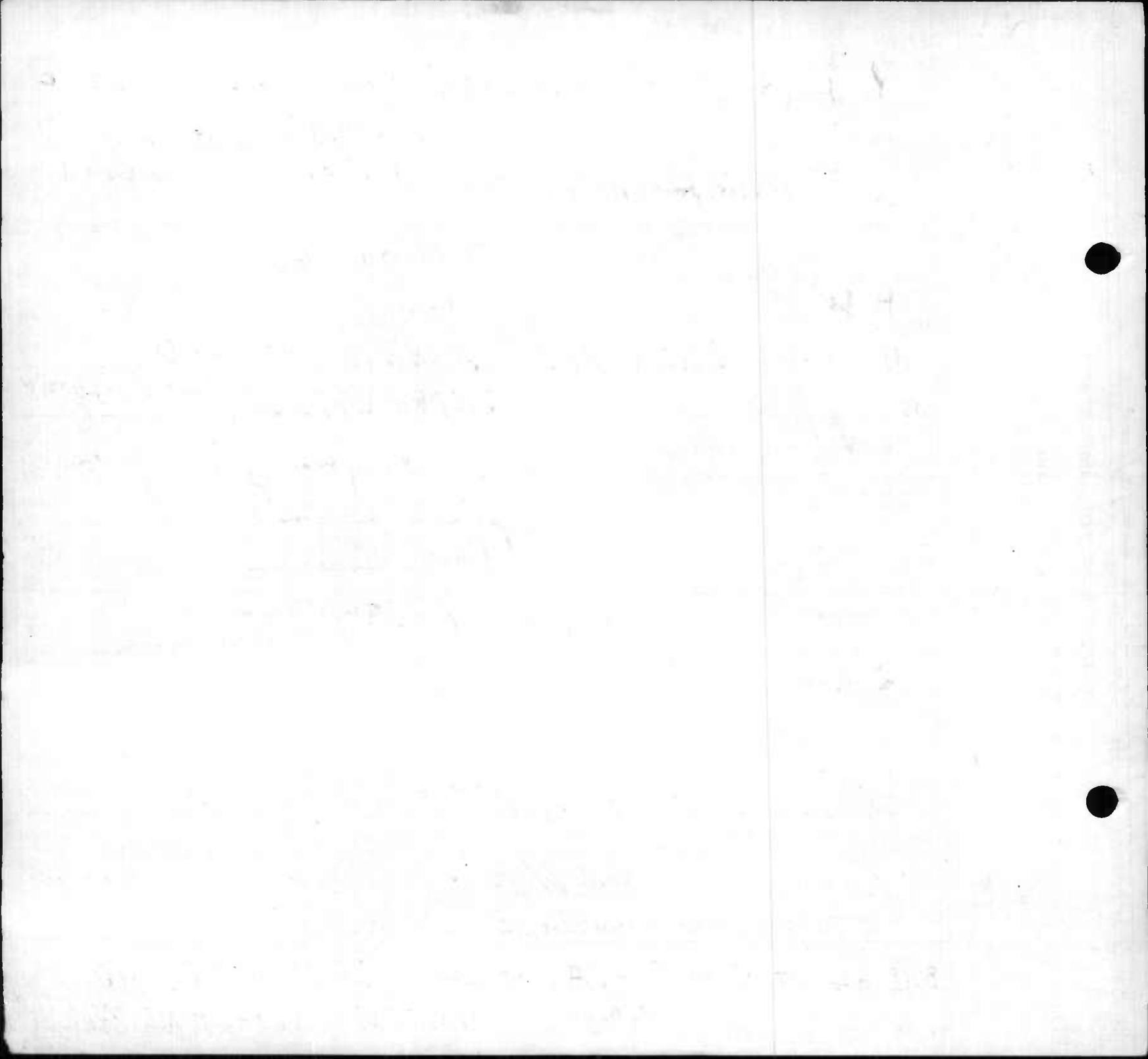
Schimunek Funeral Home, Inc.
3331 Brehms Lane

VALLEY HONOR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

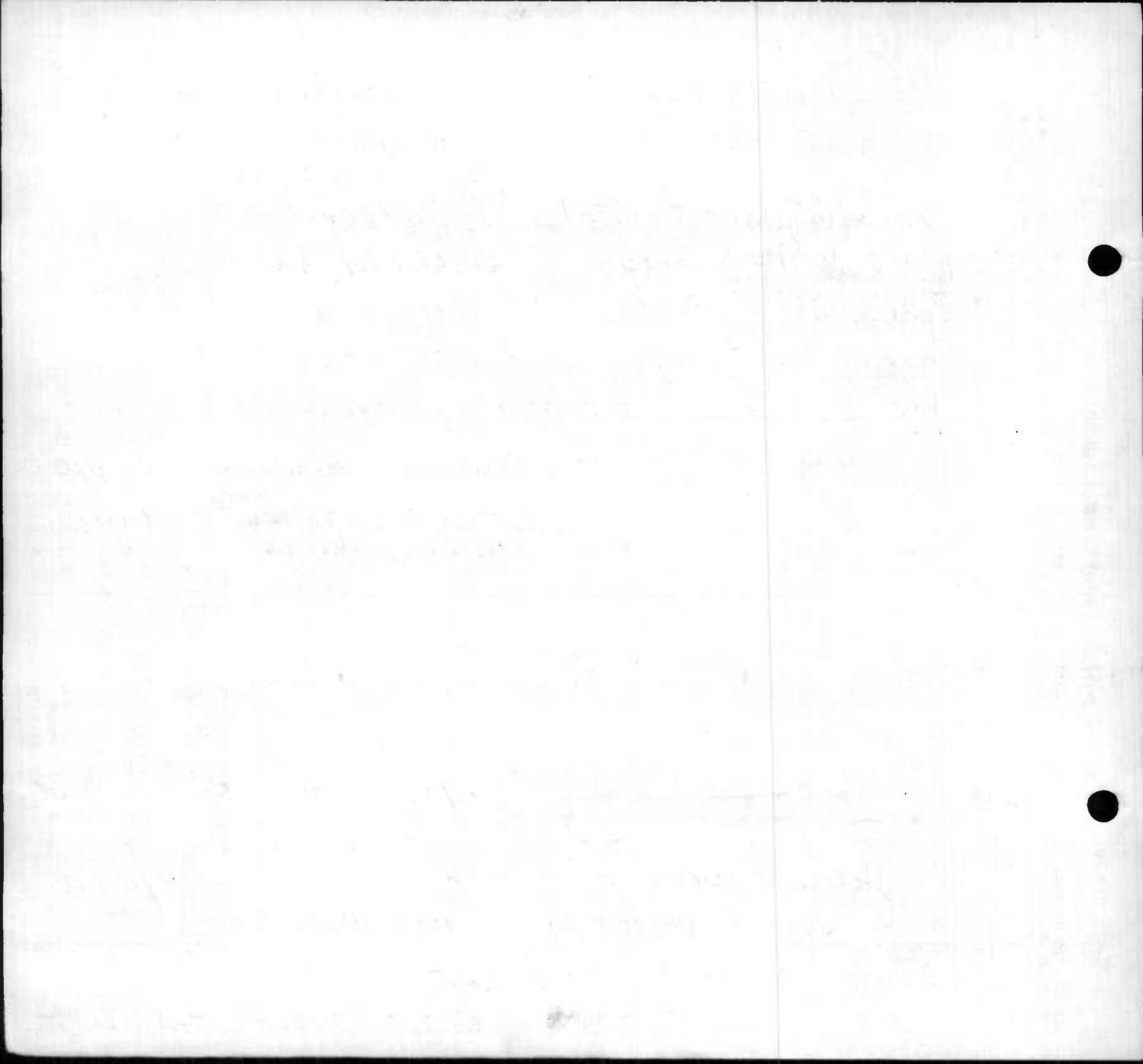
BALTIMORE CITY HEALTH DEPARTMENT														
66 04014					CERTIFICATE OF DEATH					Registered No. 66 04014				
BIRTH NO.					M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE					B. COUNTY				
38 University Hospital					410 Calhoun St. / 903					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					Baltimore					23 Md.				
D. STREET ADDRESS (If rural, give location)														
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
F		W		M		3-14-00		66						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country)				
H W										Md				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
MICHAEL BUCKHEIT					JENNIE HOWARD									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT				
NO										JOSEPH WITZLER				
										ADDRESS				
										410 S. CALHOUN ST.				
18. 572.1					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					(A) DUE TO					Respiratory insufficiency today;				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(B) DUE TO					bronchial obstruction				
ANTECEDENT CAUSES					(C) DUE TO					Pneumonia				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
II					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					Peritonitis - ruptured sigmoid				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
3:10 AM					Peritonitis					Yes				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED					21F. HOW DID INJURY OCCUR?				
					While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from 10 AM 1966 to 1 PM 1966, that (I) (we) last saw the deceased alive on 16 Apr 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										23A. SIGNATURE				
Theodore G. Dodenhoff										23B. DATE SIGNED				
										16 Apr 66				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS									
Theodore G. Dodenhoff					4-Hosp.									
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE					24C. NAME OF CEMETERY or CREMATORY				
BURIAL					4-20-66					CEDAR HILL				
24D. LOCATION (City, town, or county)					24E. DATE REC'D BY HEALTH DEPT.					24F. NAME OF REGISTRAR				
BALTIMORE, MD.					APR 20 1966					R. E. E. J. J. J.				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR					25C. FUNERAL DIRECTOR				
										WALTERS FUNERAL HOME				
										ADDRESS				
										PRATT & STRICKER				
										575.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

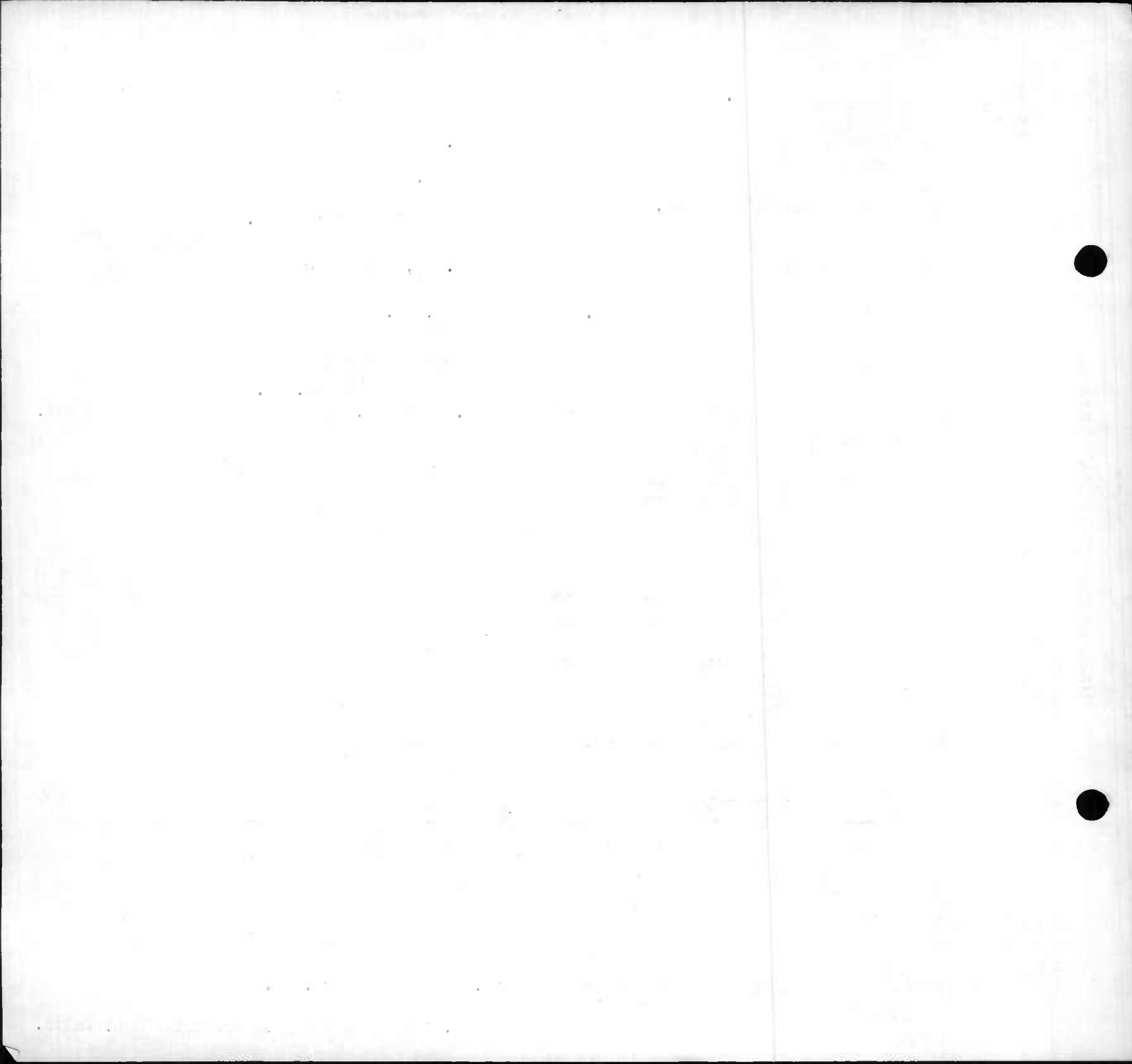
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No.	
BIRTH NO. 66 04015						66 04015	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) Milton S. Starry				2. DATE AND HOUR OF DEATH April 15, 1966 2 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Franklin Square Hospital		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 20-01	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 19 N. Monroe St.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH June 25, 1899	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cable Splicer		10B. KIND OF BUSINESS OR INDUSTRY Electric		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry W. Starry				14. MOTHER'S MAIDEN NAME Mary Logan			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 705-05-2051		17. INFORMANT Mary Musgrove		ADDRESS 114 S. Calhoun St	
18. <u>420.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerumen Occlusion Anteroselective Heart Vascular Disease II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Sudden 1 year	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4/14</u> <u>1965</u> to <u>4/15</u> <u>1966</u> , that (I) <u>last</u> last saw the deceased alive on <u>4/14</u> <u>1966</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.							
23A. SIGNATURE John P. Urlock Jr.				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/18/66	
23C. PHYSICIAN'S NAME (Type) JOHN P. URLOCK JR.				23D. ADDRESS 1227 Ward Blvo			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/19/66		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1966		25B. NAME OF REGISTRAR Robert E. Fickens		25C. FUNERAL DIRECTOR Walter Funeral Home Pratt & Stricker Etc.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

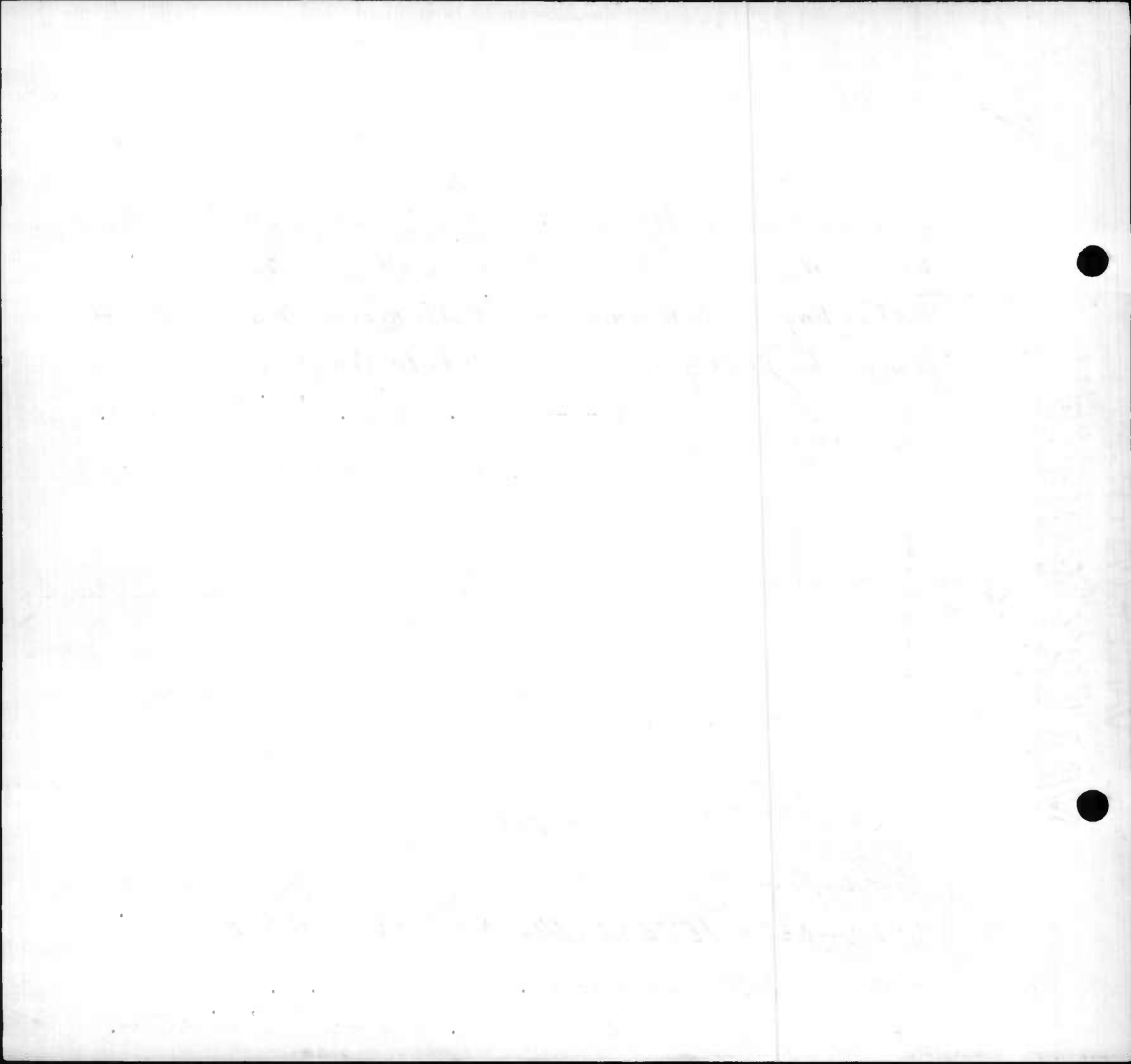
BALTIMORE CITY HEALTH DEPARTMENT				66 04016		66 04016	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Edward N. Sheeler				APRIL 18, '66 4:10 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
1228 Pine Heights Ave.				Md. 25-41			
5. SEX 6. RACE 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH 9. AGE (in years lost birthday)			
Male White Married				Nov. 30, 1919 46			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
Mechanic				Balto. Md.			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
Transfer Co.							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Lawrence Sheeler				Frieda Gilbert			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				220-03-4000			
15. INFORMANT ADDRESS				17. INFORMANT			
Balto. Md. 21229				Mrs. Norene E. Sheeler 1228 Pine Heights Ave.			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) DUE TO			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				METASTATIC CARCINOMA 16 MOS.			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				UNKNOWN PRIMARY SITE 16 MOS.			
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				NONE			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
0				NO			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
NO							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from DEC. 1964 to APRIL 18, 1966, that (I) last saw the deceased alive on APRIL 8, 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
John H. Tuohy				4/18/66			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JOHN H. TUOHY				ST. AGNES HOSPITAL BALTIMORE, MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				4/21/66			
24C. NAME OF CEMETERY OR CREMATORY				24D. LOCATION (City, town, or county) (State)			
I Loudon Park Cem.				Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
APR 20 1966				G. Truman Schwab			
25C. FUNERAL DIRECTOR				ADDRESS			
				G. Truman Schwab 3512 Frederick Ave. Balto.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

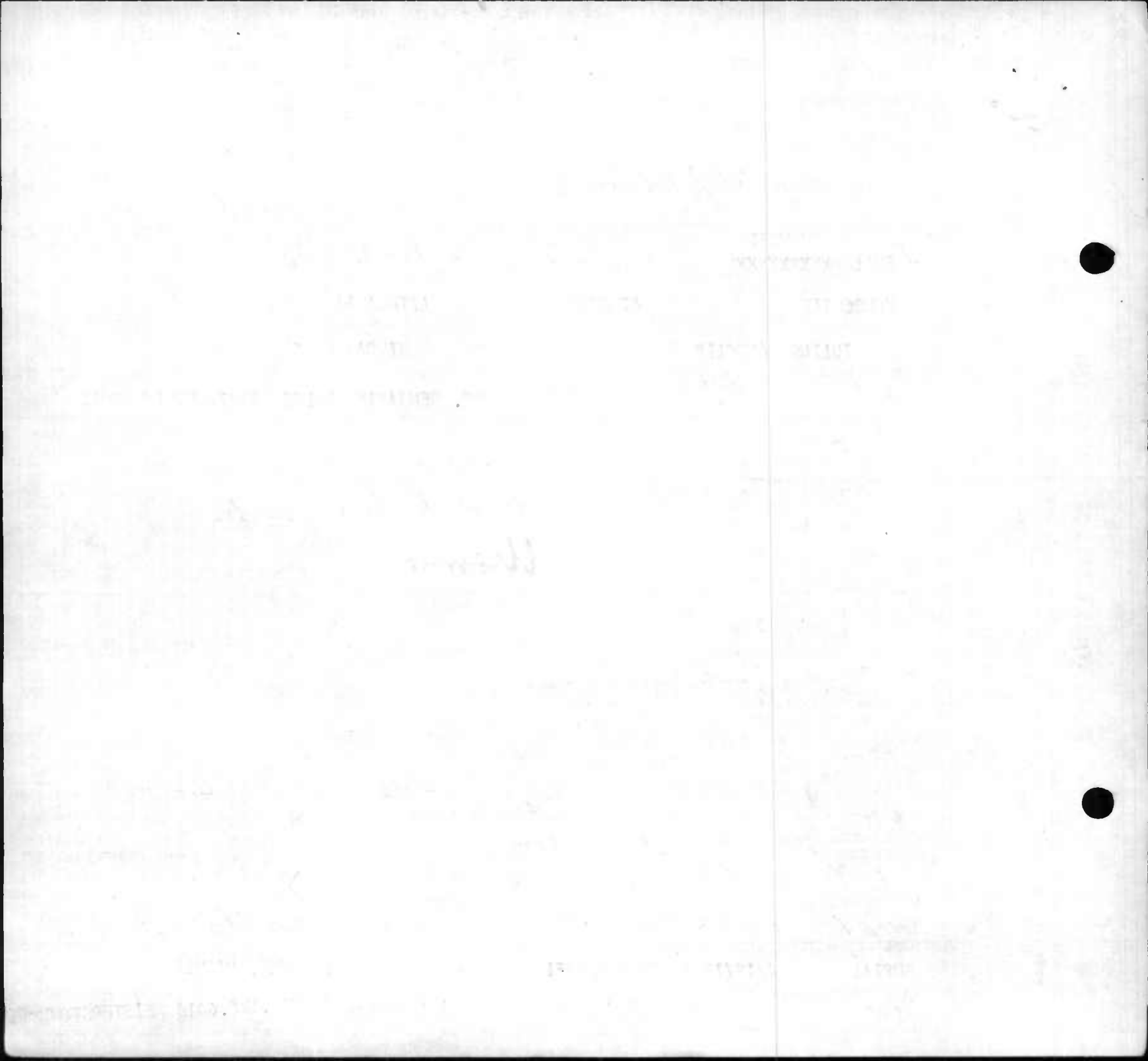
BIRTH NO. 66 04017		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04017	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) James Drury A.		2. DATE AND HOUR OF DEATH 4/18/66 8:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland 2006	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
34 Box Secours Hospital		D. STREET ADDRESS (If rural, give location)		3004 STAFFORD ST #23	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M.	8. DATE OF BIRTH 2-22-04	9. AGE (In years last birthday) 62	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STATION Eng		10B. KIND OF BUSINESS OR INDUSTRY M. MANNING INC		11. BIRTHPLACE (State or foreign country) Baltimore Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James E. Drury		14. MOTHER'S MAIDEN NAME Adele Wagner	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-6792		17. INFORMANT Mrs. Carolyn M. Drury 3004 Stafford St. Balto, Md. 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Hypertensive cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH years	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/17/1966 to 4/18/1966 that (I) (we) last saw the deceased alive on 4/18/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Cholan Reza Pezeshkian M.D.				23B. DATE SIGNED 4/18/1966	
23C. PHYSICIAN'S NAME (Type) CHOLAN-REZA PEZESHKIAN M.D.				23D. ADDRESS BEN SECOURS HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/21/66		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	
24D. LOCATION Balto, Md.		24E. FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave.		24F. ADDRESS Balto, Md. 21229	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

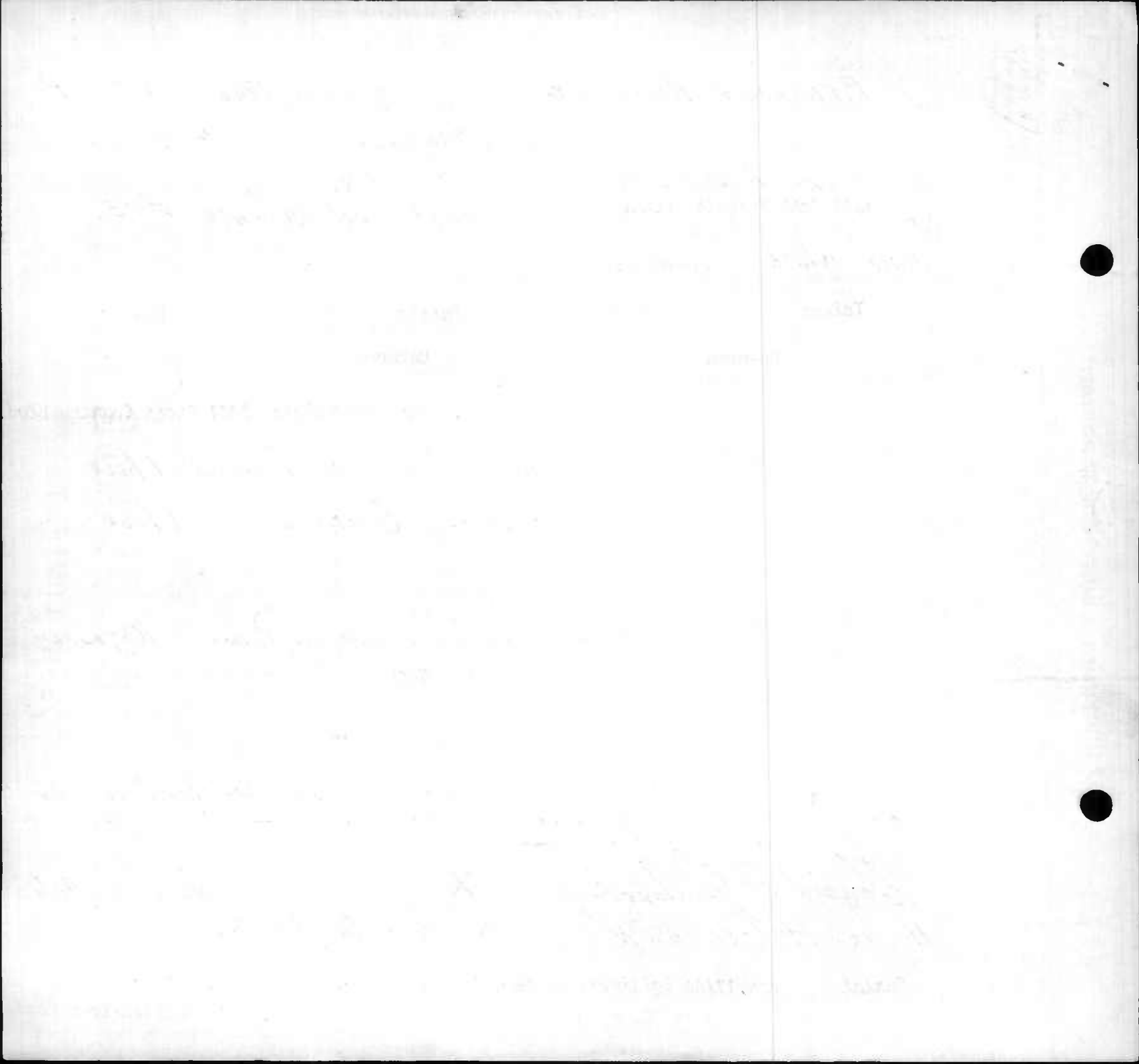
BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 66 04018					CERTIFICATE OF DEATH					Registered No. 66 04018									
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) ROSE ETHEL MEYERS					2. DATE AND HOUR OF DEATH 4-17-66 16:50 P.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 15-11					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balt.									
FULL NAME OF HOSPITAL OR INSTITUTION 428 Sinai Hospital of Baltimore					D. STREET ADDRESS (If rural, give location) 3507 Dennlyn Rd. #15														
5. SEX 9 FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH 4-15-96		9. AGE (In years lost birthday) 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY AT HOME					11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME JULIUS MARGOLIS					14. MOTHER'S MAIDEN NAME HINDA ?														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO.					17. INFORMANT MR. BENJAMIN MEYERS					ADDRESS 3507 DENNLYN ROAD				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 157X1					CAUSE OF DEATH (A) Carcinoma of pancreas DUE TO (B) metastasis, arthritis DUE TO (C) Uremia					INTERVAL BETWEEN ONSET AND DEATH									
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.																			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION 4-7-66					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA Pancreas & metastasis & arthritis					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (1) (this hospital) attended the deceased from 3-23 19 66 to 4-17 19 66 , that (1) (we) last saw the deceased alive on 4-17 19 66 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE Chare Phonprabert M.D.										23B. DATE SIGNED 4-17-66									
23C. PHYSICIAN'S NAME (Type) CHARE PHONPRABERT M.D.										23D. ADDRESS Sinai Hospital, Balt., Md.									
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE 4/19/1966					24C. NAME OF CEMETERY OR CREMATORY BNAI ISRAEL					24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND				
25A. DATE REC'D BY HEALTH DEPT. APR 20 1966					25B. NAME OF REGISTRAR Paul E. Farley					25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.					ADDRESS 6010 REISTERSTOWN RD				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04019		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 04019	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) BENJAMIN HOFFENBERG			2. DATE AND HOUR OF DEATH April 16, 1966 16²⁰ P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-16		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MT. SINAI Nursing Home 42 4613 Park Heights Avenue			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
D. STREET ADDRESS (If rural, give location) 4613 PARK HEIGHTS AVE.					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER	8. DATE OF BIRTH 81	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10B. KIND OF BUSINESS OR INDUSTRY Shop		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Harry Hoffenberg 2401 Cross Country Blvd	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CORONARY OCCLUSION			CAUSE OF DEATH (A) ACUTE MYOCARDIAL INFARCTION (B) CORONARY OCCLUSION (C) 1 hour		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE			INTERVAL BETWEEN ONSET AND DEATH 10 years		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from DEC 24 1964 to April 16 1966 , that (we) last saw the deceased alive on April 16 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Howard H. Gendason M.D.				23B. DATE SIGNED April 16, 1966	
23C. PHYSICIAN'S NAME (Type) HOWARD H. GENDASON M.D.				23D. ADDRESS 3832 Park Heights Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Apr. 17/66		24C. NAME OF CEMETERY or CREMATORY Baltimore Hebrew, 2100 Belair Rd. Baltimore, Maryland	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. APR 20 1966		25B. NAME OF REGISTRAR Paul E. Fink		25C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. 6010 Reisterstown Road	



FUNERAL DIRECTOR: IMPORTANT

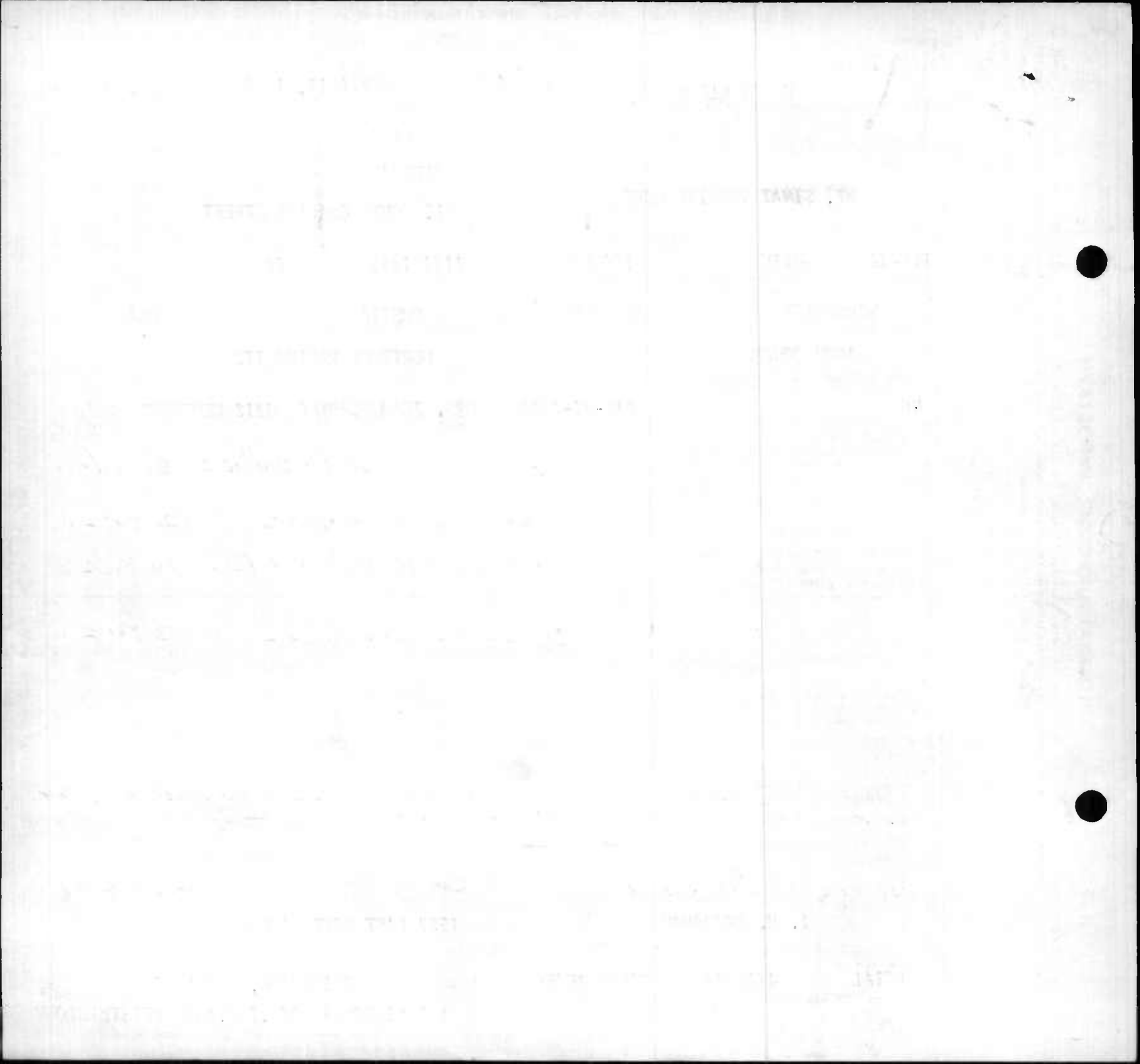
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH										Registered No. <u>66 04020</u>	
BIRTH NO. <u>66 04020</u>		M.E. CASE NO.		1. NAME OF DECEASED <u>MARCIA Lynne Garten</u> (Type or Print)				2. DATE AND HOUR OF DEATH <u>4-18-66</u> <u>5:40</u> a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Johns Hopkins Hospital</u>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>Box 809 Englemeade Road</u>					
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never married</u>		8. DATE OF BIRTH <u>6-17-51</u>		9. AGE (In years last birthday) <u>14</u>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herbert Garten</u>						14. MOTHER'S MAIDEN NAME <u>Suaan Fedder</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>216-46-7880</u>		17. INFORMANT ADDRESS <u>MR. HERBERT GARTEN ENGLEMEADE ROAD</u>					
18. CAUSE OF DEATH <u>Acute Cardiac Arrhythmia, causing intractable congestive heart failure and shock. Secondary to hypertrophic subaortic stenosis and hypertrophic subpulmonic stenosis and possible pulmonary embolus</u> INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>											
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Turner's Syndrome</u>											
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <u>NONE</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4-18-1966</u> to <u>4-18-1966</u> , that (I) (we) last saw the deceased alive on <u>4-18-1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Jay B. Jensen</u> M.D.								Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4-18-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>JAY B JENSEN</u>								23D. ADDRESS M.D. <u>The Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4/19/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>BETH TFILOH</u>				24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1966</u>				25B. NAME OF REGISTRAR <u>Robert E. Jensen</u>				25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD</u>			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 04021		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04021	
BIRTH NO.		CERTIFICATE OF DEATH			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
SARAH KLEIN		APRIL 17, 1966		12 NOON M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE			
		MARYLAND		23-01	
90 MT. SINAI NURSING HOME		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE			
		D. STREET ADDRESS (If rural, give location)			
		912 SOUTH CHARLES STREET			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
FEMALE	WHITE	WIDOWED	11/1/1885	80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		AT HOME		RUSSIA	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
USA		HARRY COHEN		GERTRUDE RABINOWITZ	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		212-42-2959		MRS. JEAN DEARING 4312 WENTWORTH ROAD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Acute Coronary Thrombosis		Sudden	
		(B) Coronary Sclerosis		2 yrs.	
		(C) Arteriosclerotic C.U.D.		10 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes Mellitus		3 yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb. 10, 1963 to April 17, 1966, that (I) (we) last saw the deceased alive on April 16, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Isidore K. Grossman M.D.		4/17/66			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
I. K. GROSSMAN		1527 EAST NORTH AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		4/18/66		RODDE ZEDEK	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
BALTIMORE, MARYLAND		APR 20 1966		Sol Levinson & Bros. Inc.	
25C. FUNERAL DIRECTOR ADDRESS		25D. NAME OF REGISTRAR		25E. FUNERAL DIRECTOR ADDRESS	
SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD		Sol Levinson & Bros. Inc.		SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD	



46-43-75

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 14022

BIRTH NO. 66-076065-4022

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Parker, Baby Boy ~~Parker~~

2. DATE AND HOUR OF DEATH

4/14/66 3 32 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue 21224

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Md Baltimore 1602

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS

(If rural, give location)

1217 Whatcoat Street 21217

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

4/14/66

9. AGE (In years
last birthday)

9 3/4 hrs

If Under 1 Yr.

Months: Days: Hours: Min.

0 0 9 32

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Patricia Parker

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

4940 Eastern Avenue

RECORDS: BCH: BALTIMORE, MARYLAND 21224

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Prematurity.

(B) DUE TO

Respiratory Arrest

(C) DUE TO

Prob. Hyaline Membrane Dis
or CNS Hemorrhage.INTERVAL BETWEEN
ONSET AND DEATH

3 hrs

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner) NO21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/14/66 6 AM 1966 to 4/14/66 1966 3:32 PM
that (I) (we) last saw the deceased alive on 4/14/66 1966 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Edward O. Jacobs M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

4/14/66

23C. PHYSICIAN'S
NAME (Type)

EDWARD O. JACOBS

M.D.

23D. ADDRESS

EASTERN AVE (4940)
BALTIMORE, MARYLAND 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Cremation

4-15-66 Baltimore City Hospitals Baltimore, Maryland 21224

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

APR 20 1966

Robert E. Fisher M.D.

HOSPITAL DISPOSAL

Be... with the...

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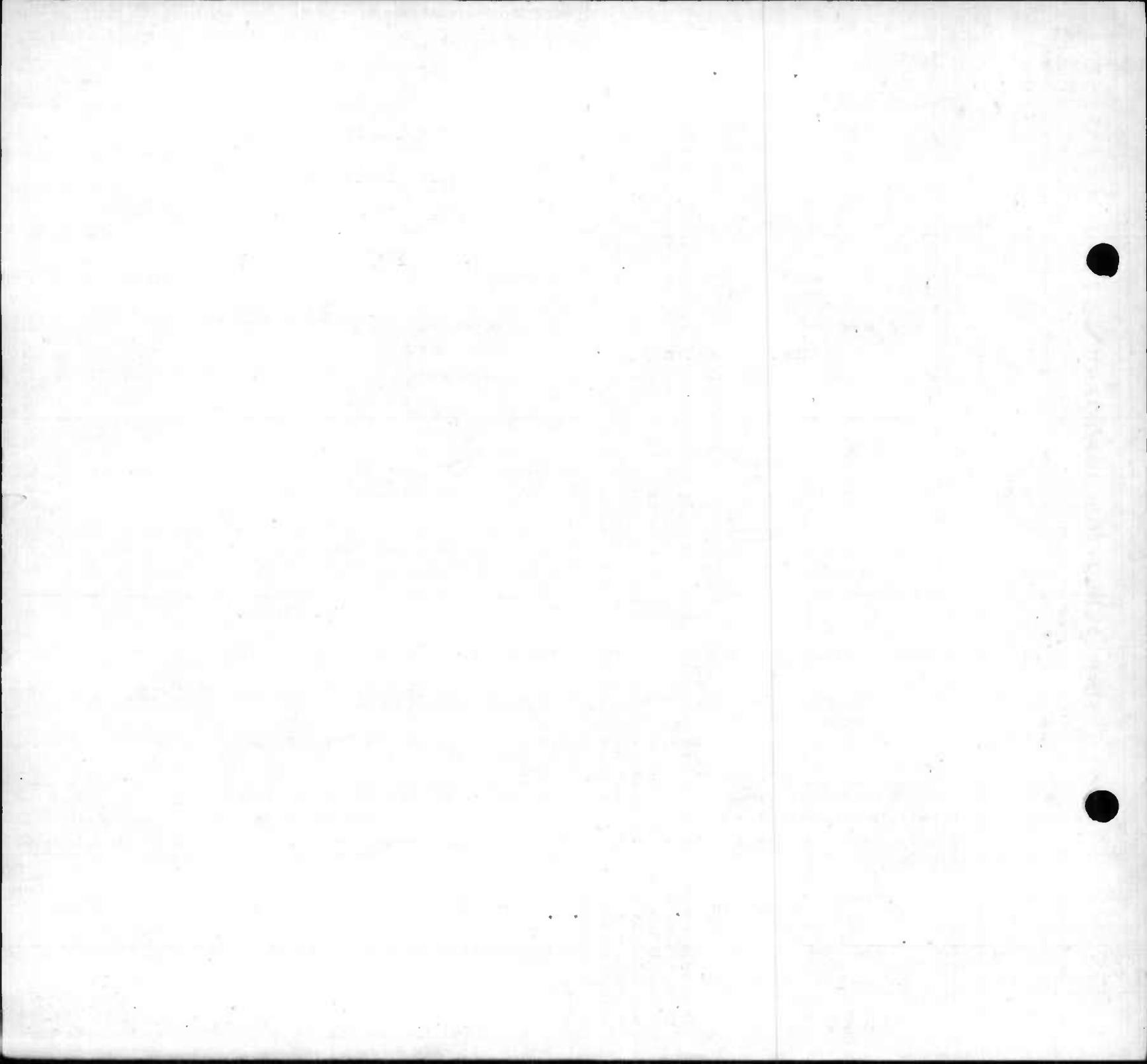
EDWARD

... ..

FUNERAL DIRECTOR: IMPORTANT

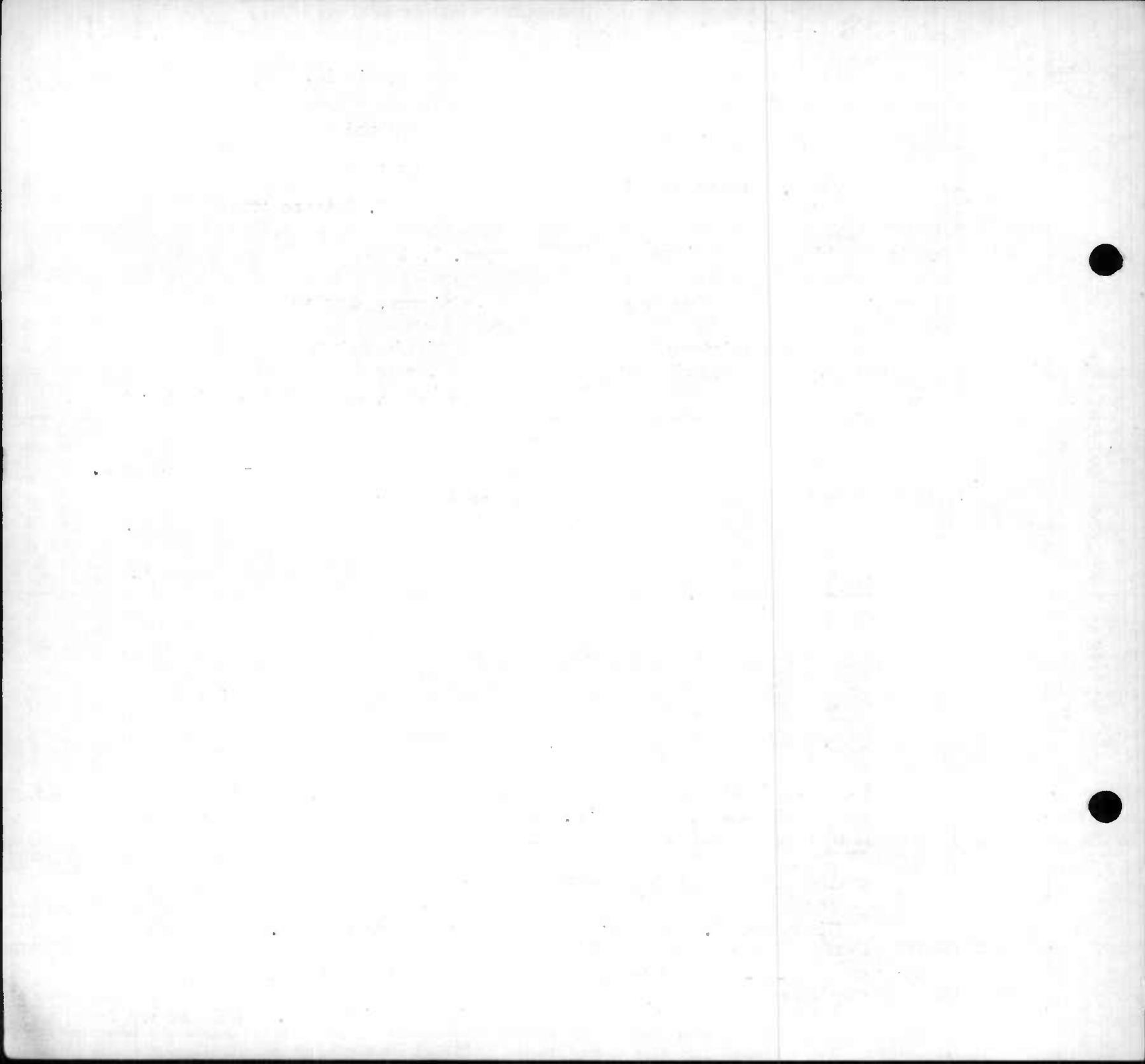
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										Registered No. 114023	
BIRTH NO. 66 04023		M.E. CASE NO.								2. DATE AND HOUR OF DEATH 4.19.66 12 ⁵⁰ P.M.	
1. NAME OF DECEASED (Type or Print) Reilly, R. Maude		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital									
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widow		8. DATE OF BIRTH 8.6 1878		9. AGE (In years last birthday) 87		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
10A. USUAL OCCUPATION		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Michael Faulkner				14. MOTHER'S MAIDEN NAME ?				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO.				17. INFORMANT Hospital Chart				ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 497X1		CAUSE OF DEATH (A) DUE TO Bronchopneumonia						INTERVAL BETWEEN ONSET AND DEATH 1 week			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO						(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Coronary Heart Disease Collapse Lumbar Vertebrae due to Osteoporosis						2 days 1 week			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (1) (this hospital) attended the deceased from 4.16.1966 to 4.19.1966, that (1) (we) last saw the deceased alive on 4.19.1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Charles E. Shaw				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 4.19.66			
23C. PHYSICIAN'S NAME (Type) Charles E. Shaw, M.D.				23D. ADDRESS 607 W. Joppa Road Baltimore, Md 21204							
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 4/20/1966		24C. NAME OF CEMETERY or CREMATORY Our Lady Grace				24D. LOCATION (City, town, or county) (State) Philadelphia, Pennsylvania			
25A. DATE REC'D BY HEALTH DEPT. APR 20 1966		25B. NAME OF REGISTRAR P. E. E. Faulkner				25C. FUNERAL DIRECTOR Wm. J. Tichner & Son, Inc.					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH									
BIRTH NO. 66 04024		Registered No. 66 04024							
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) KATE REAGAN				2. DATE AND HOUR OF DEATH April 18, 1966 5:20 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 908 S. Potomac Street					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 908 S. Potomac Street				
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH Nov. 1, 1885	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Weistner					14. MOTHER'S MAIDEN NAME Minnie Kaiser				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Charles Reagan 3117 Fleet Street				
18. CAUSE OF DEATH									
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO Arteriosclerotic Cardio-vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.		
					(B) DUE TO				
					(C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from July 19 52 to April 19 66 , that (I) (we) last saw the deceased alive on Apr. 16 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Clarence W. LeDoux</i> M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 4/18/66	
23C. PHYSICIAN'S NAME (Type) Clarence W. LeDoux M.D.					23D. ADDRESS 3023 Eastern Ave.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-21-1966		24C. NAME OF CEMETERY or CREMATORY Schwartz			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. APR 20 1966			25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>			25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04025

BIRTH NO. 66 04025

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GENEVA EVANS

2. DATE AND HOUR PRONOUNCED DEAD

April 14, 1966 12:28 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY 7-04

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2043 E. Eager Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

April 12, 1899

9. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Lamar, S.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Osborne Casey

14. MOTHER'S MAIDEN NAME

Addie McFadden

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Archie Barber 3303 Dunes St

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
4/15/6623A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 20 1966

Robert E. Jenkins, M.D.

Milton E. Elckson 1129 N. Carroll St

WALLER FOLIO

1940 CONTENT

USA

0

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN EARL

Scheuerman
SCHEUERMAN

2. DATE AND HOUR PRONOUNCED DEAD

April 16, 1966

10:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 28

D. STREET ADDRESS (If rural, give location)

6639 Frederick Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec. 12/02

9. AGE (in years
last birthday)

63

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Chief, A.R. Bureau

10B. KIND OF BUSINESS OR INDUSTRY

B. & O.R.R.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Louis Scheuerman

14. MOTHER'S MAIDEN NAME

Elizabeth-p---

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

705 09 0017

17. INFORMANT

ADDRESS

Bertha L. Scheuerman (Same)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
4/17/6623A. BURIAL CREMATION,
REMOVAL (Specify)

burial

23B. DATE

4/20/66

23C. NAME OF CEMETERY or CREMATORY

Loudon Park

24A. DATE REC'D BY HEALTH DEPT.

APR 20 1966

24B. NAME OF REGISTRAR

Robert E. Felt

24C. FEE

VALLEY FORGE

RECEIVED

Dec. 12/11

Boiler

8.2.11

Boiler

Boiler

Boiler

Boiler

[Handwritten signature]

Boiler

Boiler

Boiler

BIRTH NO.

66 04027

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 04027

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

KATHERINE HARVEY

2. DATE AND HOUR PRONOUNCED DEAD

April 16, 1966 10:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

4714 Eastern Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4714 Eastern Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

7/17/1900

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

H.W.

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Cath Theodore Schmidt

14. MOTHER'S MAIDEN NAME

Honrietta

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

215-30-5194A

17. INFORMANT

ADDRESS

Mrs. Grace Leland (Sister)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
4/17/6623A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/20/66

23C. NAME OF CEMETERY or CREMATORY

Laudoy

23D. LOCATION (City, town, or county) (State)

Baltimore, Md

24A. DATE REC'D BY HEALTH DEPT.

APR 20 1966

24B. NAME OF REGISTRAR

Robert E. [unclear]

24C. FUNERAL DIRECTOR

Wibke F. W. 4101

ADDRESS

Edmondson

WALLLEY FORDS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. <u>64-22047</u> <u>66 04028</u>					CERTIFICATE OF DEATH			Registered No. <u>66 04028</u>	
M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
Kevin Grady					April 18, 1966 9:30p				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
Provident Hospital 1514 Division Street Baltimore, Maryland 21217					Maryland 18-02				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					Baltimore				
					D. STREET ADDRESS (If rural, give location)				
					1005 W. Mulberry Street				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Male	Negro	single	Aug. 13, 1964	20 months	None	Maryland	U.S.A.	Lee Smith	Selena Grady
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
						Selena Grady-mother same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH				
(A) Acute purulent meningitis DUE TO									
(B) Bronchopneumonia DUE TO									
(C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 17, 1966 to April 18, 1966, that (I) (we) last saw the deceased alive on April 18, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE L. C. Rose						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED April 18, 1966	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS			
L. C. Rose						1514 Division Street-Baltimore, Md			
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE			24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial			4/21/1966			Mt. Carmel Cem.		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS			
APR 20 1966			R. E. E. Fisher			Williams Funeral Home 318 N. Schroeder St			

Maryland
Baltimore
1005 W. McIlhenny Street

Provident Hospital
1514 Division Street
Baltimore, Maryland 21217

1958-1959
Maryland
Selena Grady
Selena Grady-mother
same

Male
Negro
single
None
unknown

acute suppurative meningitis
bronchopneumonia

yes

April 18, 66

April 17, 66

April 18, 66

April 18, 66

1514 Division Street-Baltimore, MD

L. C. Rose

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>66 04029</u>	
BIRTH NO. <u>66 04029</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Lucille Gaines (Nicholas)</u>		2. DATE AND HOUR OF DEATH <u>April 17, 1966</u> <u>11:45</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1881</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>202 Fremont Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jim Gaines</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Moore</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-09-0690</u>		17. INFORMANT ADDRESS <u>Lucy White 817 W. Saratoga St.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>5938 I</u> <u>A Zote mia</u> <u>Kidney failure</u>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>April 13, 1966</u> to <u>April 17, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 17, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Dr. Roger Theodore</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>April 18, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Roger Theodore</u>				23D. ADDRESS M.D. <u>1514 Division Street</u>			
24A. BURIAL CREMATION, REMOVAL (specify) <u>Burial</u>		24B. DATE <u>4/20/1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE RECEIVED BY HEALTH DEPT. <u>APR 20 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Schaefer</u>		25C. FUNERAL DIRECTOR <u>William F. Rame</u>		ADDRESS <u>3199 Schaefer St.</u>	

4-5-68

1905 Fremont Avenue
Baltimore, Maryland

1914 Division Street
Baltimore, Maryland

Unknown

Female Negro

Virginia

Yes

Yes

April 15, 68

April 15, 68

April 17, 68

April 15, 68

x

1914 Division Street

Dr. Roger Theodore

BIRTH NO.		M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
66 04030		D-120		ROBERT DAVIS		April 16, 1966		10:30 A M.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE				B. COUNTY	
732 W. Mulberry Street				Maryland					
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)					
				Baltimore				17-03	
				D. STREET ADDRESS (If rural, give location)					
				732 W. Mulberry Street					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Male	Negro	Single	Nov. 4, 1893	72	Laborer		Kershaw S.C.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Egza Davis				Nannie Smith					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes WWI				244-04-3453		Bertie Banks		732 W. Mulberry St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
422.10-260X				Arteriosclerotic Cardiovascular Disease.					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO					
ANTECEDENT CAUSES				(B) DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(C) DUE TO					
II				Diabetes Mellitus.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				No					
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type)				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				4/17/66	
Charles S. Petty, M.D.				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county)		(State)	
Burial		April 20, 1966		Baltimore National Cem.		Baltimore Md.			
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS			
APR 20 1966		Robert E. Farber		Williams Funeral Home		314 N. Schroeder St.			

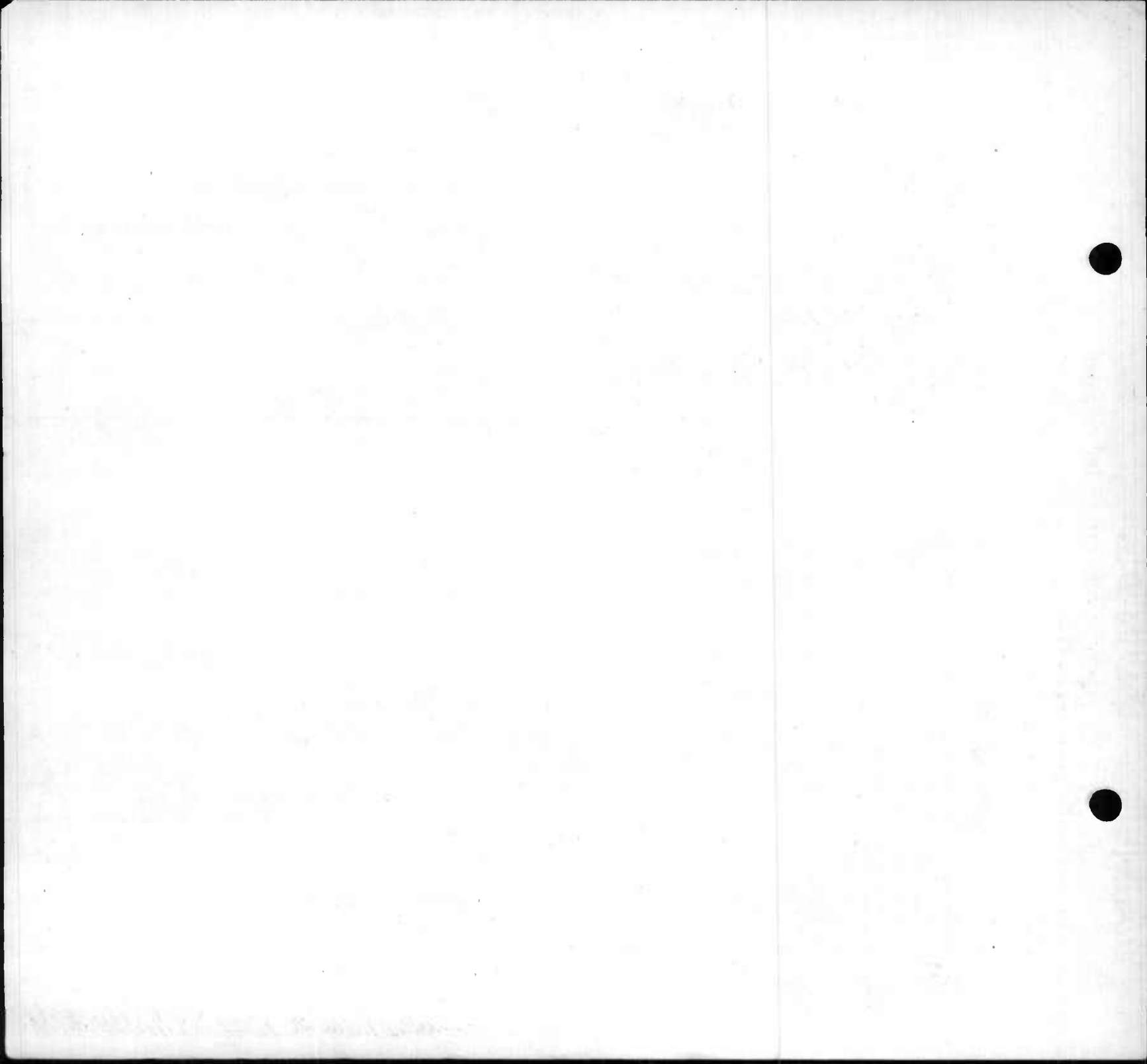
WALLIE V. BOHRE

PAID 50114

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 14031	
BIRTH NO. 66 04031		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GRANT, VIOLA		2. DATE AND HOUR OF DEATH 3 ²⁵ April 16, 1966 3 ²⁵ M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 Franklin Square Hospital.				A. STATE Maryland		B. COUNTY 18-01	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 23.			
D. STREET ADDRESS (If rural, give location) 15 N. Amity St.							
5. SEX female	6. RACE colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH Jan. 10, 1912	9. AGE (If years last birthday) 54	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgetown S.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Bowen				14. MOTHER'S MAIDEN NAME P.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Sadie Walters 1000 Hollins St.			
18. CAUSE OF DEATH 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) DUE TO post. myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH	
				(B) DUE TO			
				(C) DUE TO			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 16, 1966 to April 16, 1966, that (I) (we) last saw the deceased alive on April 16, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jong-Hi Bek				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED April 16, 1966	
23C. PHYSICIAN'S NAME (Type) TONG-HI BEK				23D. ADDRESS Franklin Square Hospital.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE April 12, 1966		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1966		25B. NAME OF REGISTRAR R. E. E. F. F.		25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 319 N. Schenck St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 04032	
BIRTH NO. 66 04032		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PITTS, Herbert Lee		2. DATE AND HOUR OF DEATH April 18, 1966 11:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U.S. Public Health Service Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 913 Chauncy Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH December 20, 1914	9. AGE (in years last birthday) 51	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) American Seaman			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Robert Pitts			14. MOTHER'S MAIDEN NAME Emma Facean				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes U.S. Army 1942			16. SOCIAL SECURITY NO. 223-05-7354		17. INFORMANT Records - USPHS Hospital, Baltimore, Maryland		ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 151X I Carcinoma of Stomach with hepatic metastases				INTERVAL BETWEEN ONSET AND DEATH 4 years			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO		(B) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 28, 1965 to April 18, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 18, 1966 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE Alvin Stein				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-19-66	
23C. PHYSICIAN'S NAME (Type) Alvin Stein, Surgeon				23D. ADDRESS M.D. U.S.P.H.S. Hospital, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE April 23, 1966		24C. NAME OF CEMETERY, CREMATORY Balto National Cem. Balto Md		24D. LOCATION (City, town or county) (State) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1966		25B. NAME OF REGISTRAR Robert E. Fildana		25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 319 N. Schenck St.	

THE VIRGINIA

WEEKLY NEWS

AND

THE LANCET

THE VIRGINIA

THE VIRGINIA

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THE VIRGINIA

THE LANCET

THE VIRGINIA

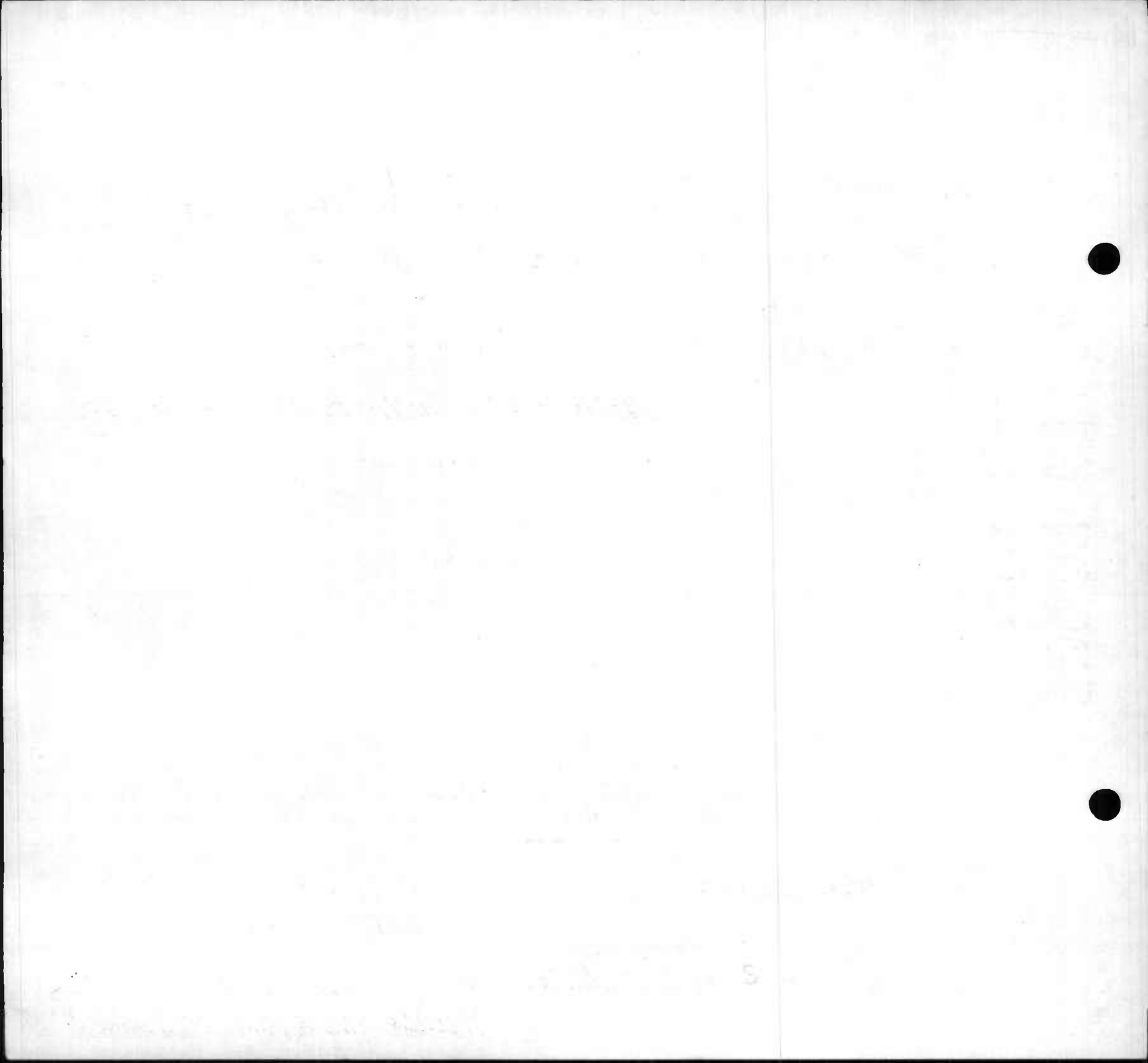
THE LANCET

THE VIRGINIA

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04033		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04033	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GEORGE BLAIR		2. DATE AND HOUR OF DEATH 10 APR 1966 5 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 8-01		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL BALTO, MD		D. STREET ADDRESS (If rural, give location) 933 W. FRANKLYN ST		E. DATE OF BIRTH 5/20/1919	
F. SEX M		G. RACE NEGRO		H. AGE (In years last birthday) 46	
I. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED		J. DATE OF BIRTH		K. AGE (In years last birthday)	
L. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		M. KIND OF BUSINESS OR INDUSTRY		N. BIRTHPLACE (State or foreign country) SOUTH CAROLINA	
O. CITIZEN OF WHAT COUNTRY?		P. FATHER'S NAME Paul BLAIR		Q. MOTHER'S MAIDEN NAME Annie Sommers	
R. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) +		S. SOCIAL SECURITY NO. 257-76-4432		T. INFORMANT ADDRESS Dorothy Woods 103 S. Catherine St.	
U. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 340.3 I		V. CAUSE OF DEATH (A) Due TO Bronchopneumonia		W. INTERVAL BETWEEN ONSET AND DEATH	
X. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Y. DUE TO (B) Due TO Meningitis chronic		Z. DUE TO (C) Due TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
AA. DATE OF OPERATION		AB. CONDITION FOR WHICH OPERATION WAS PERFORMED		AC. AUTOPSY? (Yes or No)	
AD. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		AE. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		AF. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
AG. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		AH. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		AI. HOW DID INJURY OCCUR?	
AJ. I certify that (I) (this hospital) attended the deceased from 4/17 19 66 to 4/18 19 66 , that (I) (we) last saw the deceased alive on 4/17 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
AK. SIGNATURE MBA Oldstone		AL. PHYSICIAN'S NAME (Type) University Hospital		AM. DATE SIGNED 18 APR 1966	
AN. BURIAL CREMATION, REMOVAL (Specify) Burial		AO. DATE 4/23/1966		AP. NAME of CEMETERY or CREMATORY St. Luke's Cemetery	
AQ. DATE REC'D BY HEALTH DEPT.		AR. NAME OF REGISTRAR Robert E. Farber		AS. FUNERAL DIRECTOR William Funeral Home	
AT. DATE APR 20 1966		AU. ADDRESS 319 N. Schroeder St.		AV. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 04034 CERTIFICATE OF DEATH					Registered No. 66 04034				
BIRTH NO. 66 04034					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) EVA GORDON					2. DATE AND HOUR OF DEATH 9-4 4-17-66 4:00 A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1802 EUTAW PLACE				
5. SEX FEMALE	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 9-17-78	9. AGE (In years lost birthday) 87	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WILLIAM W. REILLEY					14. MOTHER'S MAIDEN NAME CARRIE GUY				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 579-22 3618A		17. INFORMANT Waldorf, Md Eva Dodson Route " Box 183 B		ADDRESS		
18. 433.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) COMPLETE HEART BLOCK ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 15 YRS				
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (1) (this hospital) attended the deceased from 3/23 1966 to 4/17 1966, that (1) (we) lost saw the deceased alive on 4/17/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE J R SPENCER					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/17/66		
23C. PHYSICIAN'S NAME (Type) J R SPENCER					23D. ADDRESS M.D. JOHNS HOPKINS				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4/21/1966		24C. NAME OF CEMETERY or CREMATORY Cedar Hill		24D. LOCATION (City, town, or county) (State) Suitland, Md		
25A. DATE REC'D BY HEALTH DEPT. APR 20 1966			25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Robert A. Mattingly 131-1122 E. W. 1122				

172

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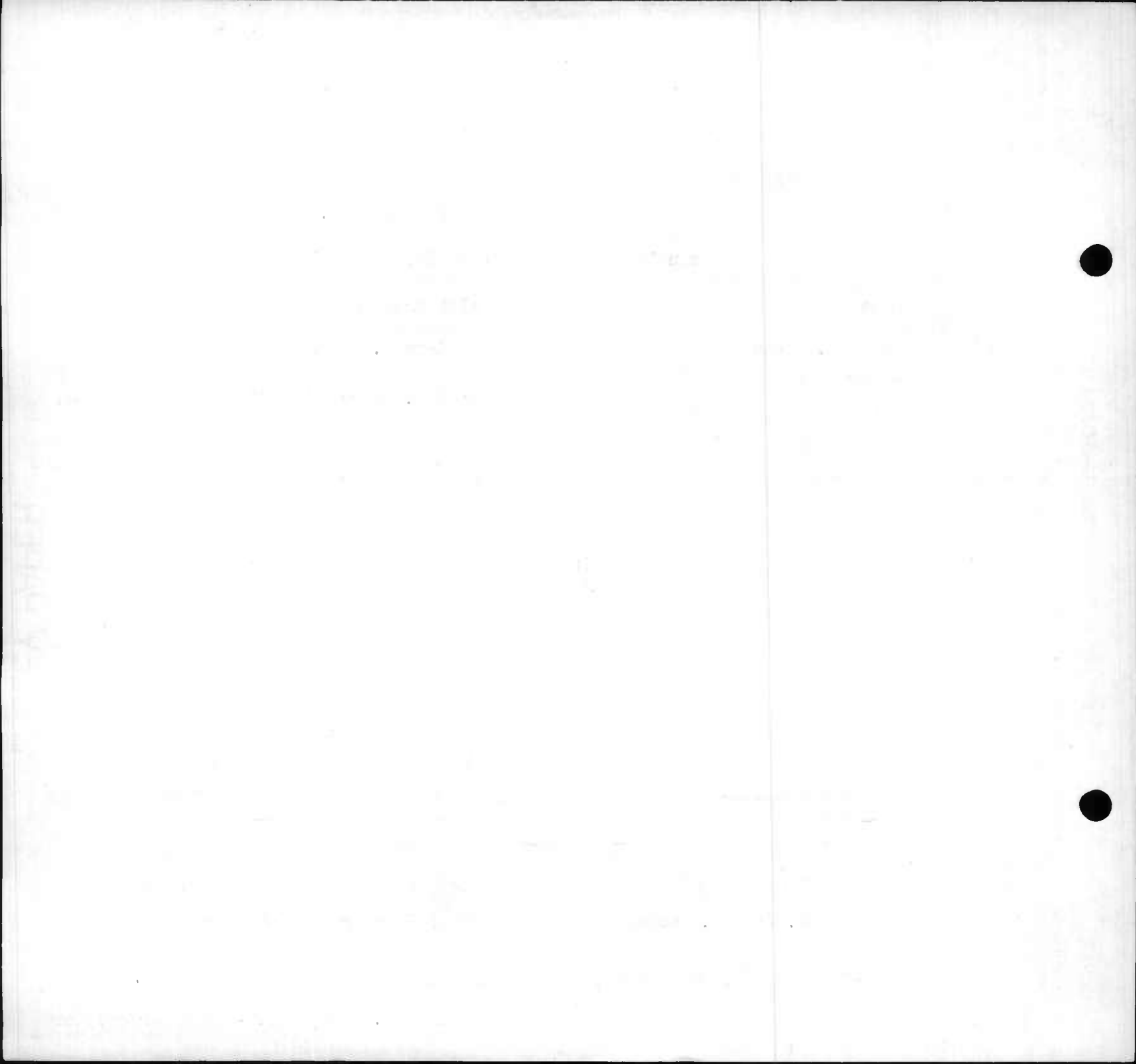
100

100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

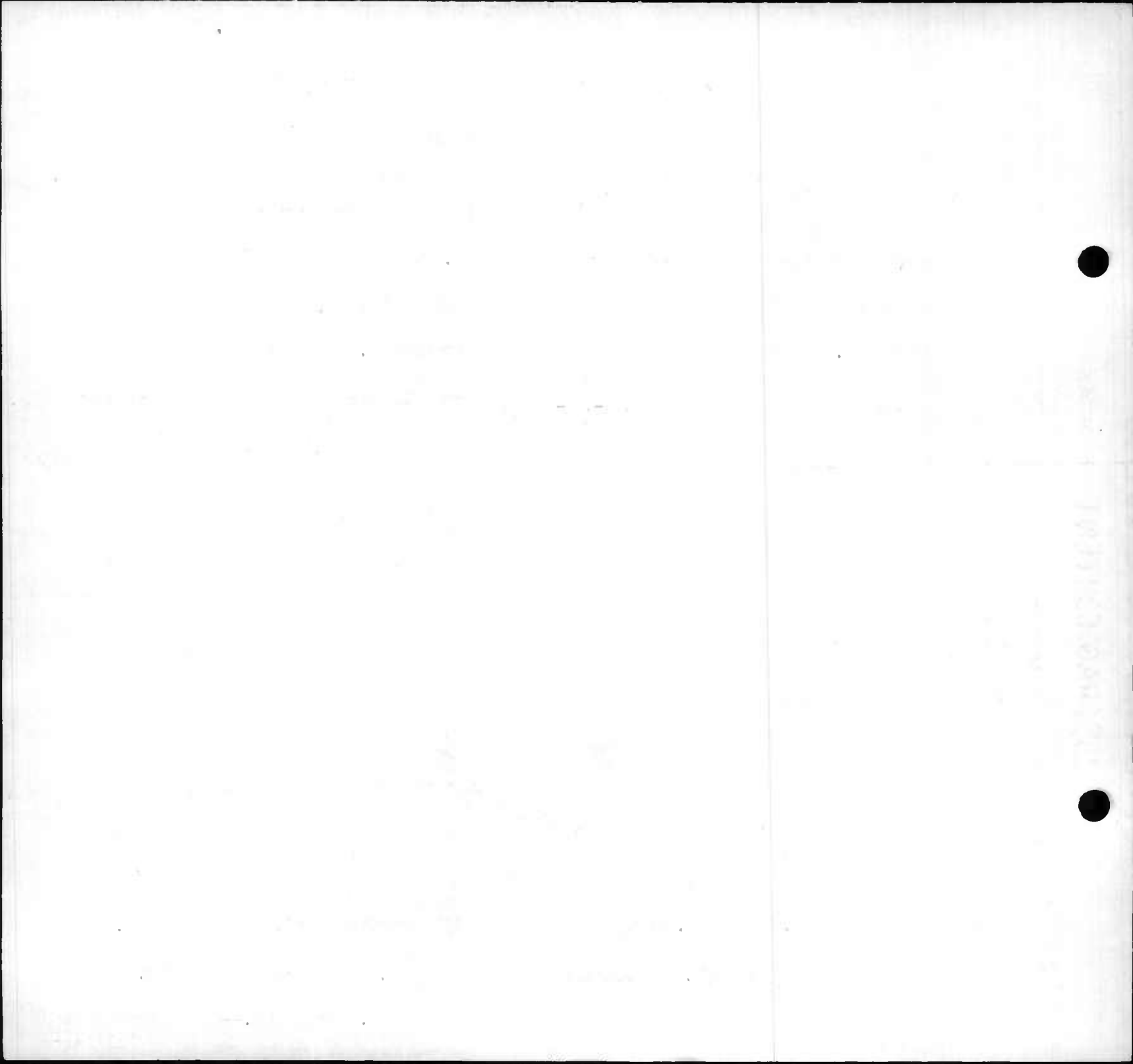
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04035	
BIRTH NO. 66 04035				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) FRANCIS WILLIAM LEONO			2. DATE AND HOUR OF DEATH April 20, 1966 2 45 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3619 Mary Avenue			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY none C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #6 D. STREET ADDRESS (If rural, give location) 3612 Mary Ave.		
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) single	8. DATE OF BIRTH March 26, 1949	9. AGE (In years last birthday) 17	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Frank C. Leono			14. MOTHER'S MAIDEN NAME Clara M. Washington		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Frank C. Leono ADDRESS 3612 Mary Ave., Balto.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 752 X1 CONGENITAL HYDROCEPHALUS (A) DUE TO 17 yrs			INTERVAL BETWEEN ONSET AND DEATH 17 yrs		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II CHRONIC PYELONEPHRITIS (B) DUE TO (C) CHRONIC PYELONEPHRITIS					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/26 19 49 to 4/20 19 66 , that (I) was last saw the deceased alive on 4/19 19 66 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.					
23A. SIGNATURE Dr. John W. Machen M.D.				23B. DATE SIGNED 4/20/1966	
23C. PHYSICIAN'S NAME (Type) Dr. John W. Machen				23D. ADDRESS 6331 Belair Road Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 4/23/66		24C. NAME OF CEMETERY or CREMATORY Garden of Faith Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. APR 20 1966		25B. NAME OF REGISTRAR R. E. Jenkins		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. - 5305 Harford Road	



FUNERAL DIRECTOR: IMPORTANT

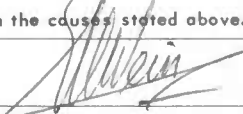
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

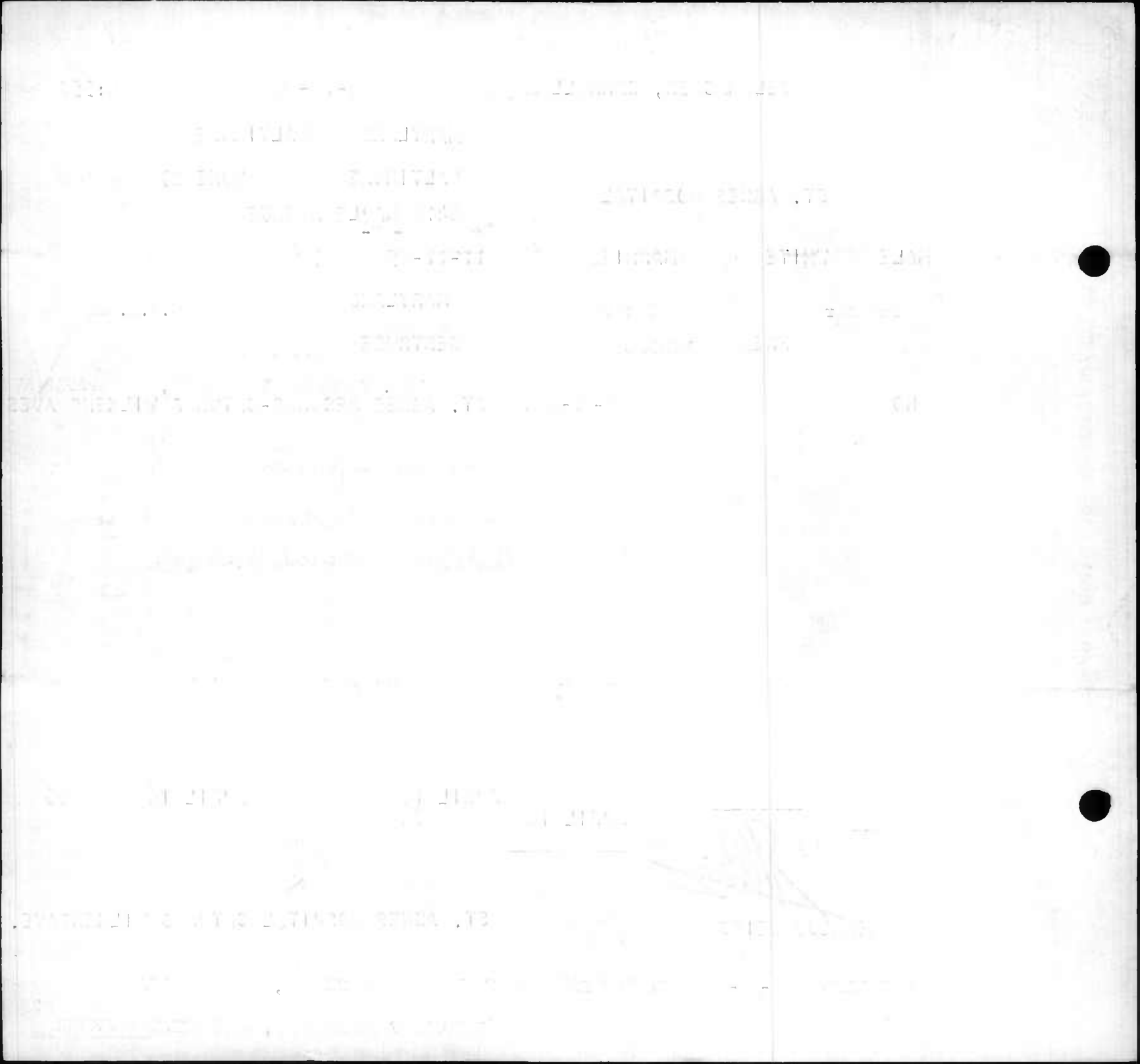
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04036			
M.E. CASE NO. 66 04036				CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) KATHARINE J. PLUMMER				2. DATE AND HOUR OF DEATH April 20, 1966 12 ¹⁰ A.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B. COUNTY Baltimore							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) residence 3106 Northern Parkway E.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore							
				D. STREET ADDRESS (If rural, give location) 3106 E Northern Parkway							
5. SEX female		6. RACE white		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH Nov. 7, 1896		9. AGE (In years last birthday) 69		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Berryville, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alford R. Showman				14. MOTHER'S MAIDEN NAME Margaret L. Castleman							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212-10-3577B		17. INFORMANT Hiram Plummer				ADDRESS 3106 Northern Parkway, Balto.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Myocardial Infarction (B) Coronary Thrombosis (C) Diabetes Mellitus				INTERVAL BETWEEN ONSET AND DEATH 4/19/66 yes. yes			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 4/18/66 to 4/20/66, that (I) (we) last saw the deceased alive on 4/18/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.											
23A. SIGNATURE Walter E. Karfjin				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>				23B. DATE SIGNED 4/20/66			
23C. PHYSICIAN'S NAME (Type) Dr. Walter E. Karfjin				23D. ADDRESS M.D. 4331 Harford Road, Baltimore, Md.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/22/66		24C. NAME of CEMETERY or CREMATORY Baltimore National Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT. APR 20 1966				25B. NAME OF REGISTRAR Robert E. Tully, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruch, Inc.--5305 Harford Road				ADDRESS Baltimore	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
66 04037					CERTIFICATE OF DEATH					Registered No. 66 04037									
BIRTH NO.					M.E. CASE NO.					1. NAME OF DECEASED (Type or Print)									
66 04037					GELDMACHER, CARROLL H, SR.					2. DATE AND HOUR OF DEATH 4-16-66 4:35A M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)										MARYLAND BALTIMORE									
ST. AGNES HOSPITAL										C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE ZONE 27									
D. STREET ADDRESS (If rural, give location) 4418 MAPLE AVENUE																			
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 11-12-95		9. AGE (In years lost birthday) 70 70		10. If Under 1 Yr. Months Days		10. If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printed					10B. KIND OF BUSINESS OR INDUSTRY Retired					11. BIRTHPLACE (State or foreign country) MARYLAND									
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME FRED GELDMACHER					14. MOTHER'S MAIDEN NAME GERTRUDE									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 213-03-8815					17. INFORMANT MRS. FLORENCE GELDMACHER, 4418 MAPLE AVE ST. AGNES RECORDS-CATON & WILKENS AVES									
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(A) DUE TO Myocardial Infarction					INTERVAL BETWEEN ONSET AND DEATH 5 hours				
										(B) DUE TO Coronary Ischemia					1 year				
										(C) DUE TO Arteriosclerotic Cardiovascular Disease									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) NO					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from APRIL 16 19 to APRIL 16 1966, that (I) (we) last saw the deceased alive on APRIL 16 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE 										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED				
23C. PHYSICIAN'S NAME (Type) EVALDO WEISS										M.D. 23D. ADDRESS ST. AGNES HOSPITAL CATON & WILKENS AVE.									
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE 4-19-66					24C. NAME OF CEMETERY or CREMATORY LOUDON PARK CEMETERY					24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND				
25A. DATE REC'D BY HEALTH DEPT. APR 20 1966					25B. NAME OF REGISTRAR R. E. E. E.					25C. FUNERAL DIRECTOR HUBBARD FUNERAL HOME, 4107 WILKENS AVENUE					#29				



66 14038

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 14038

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Glen Richard Grove

2. DATE AND HOUR PRONOUNCED DEAD

4/17/66 11:15 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Cecil

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Rising Sun

D. STREET ADDRESS (If rural, give location)

Box 128

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Jan. 4, 1925

9. AGE (In years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Forman

10B. KIND OF BUSINESS OR INDUSTRY

Wily Mfg. Co.

11. BIRTHPLACE (State or foreign country)

Penn.

12. CITIZEN OF
WHAT COUNTRY?
U. S. A.

13. FATHER'S NAME

Charles Grove

14. MOTHER'S MAIDEN NAME

Catherine Baursox

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

Yes

5-6-43

2-2-46

16. SOCIAL
SECURITY NO.

216-16-5717

17. INFORMANT

ADDRESS

Mrs. Glen Grove Rising Sun Md. Box 128

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

street

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

Rte. 276 - Cecil Co.-near Rising Sun, Md.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
4 15 66 8:00p

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

driver in auto-auto collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner H. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/18/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4-20-66

23C. NAME OF CEMETERY or CREMATORY

Brookview Cem.

23D. LOCATION

(City, town, or county)

Rising Sun

(State)

Maryland

24A. DATE REC'D BY HEALTH DEPT.

APR 20 1966

24B. NAME OF REGISTRAR

Robert E. [Signature]

24C. FUNERAL DIRECTOR

[Signature]

ADDRESS

Rising Sun Md

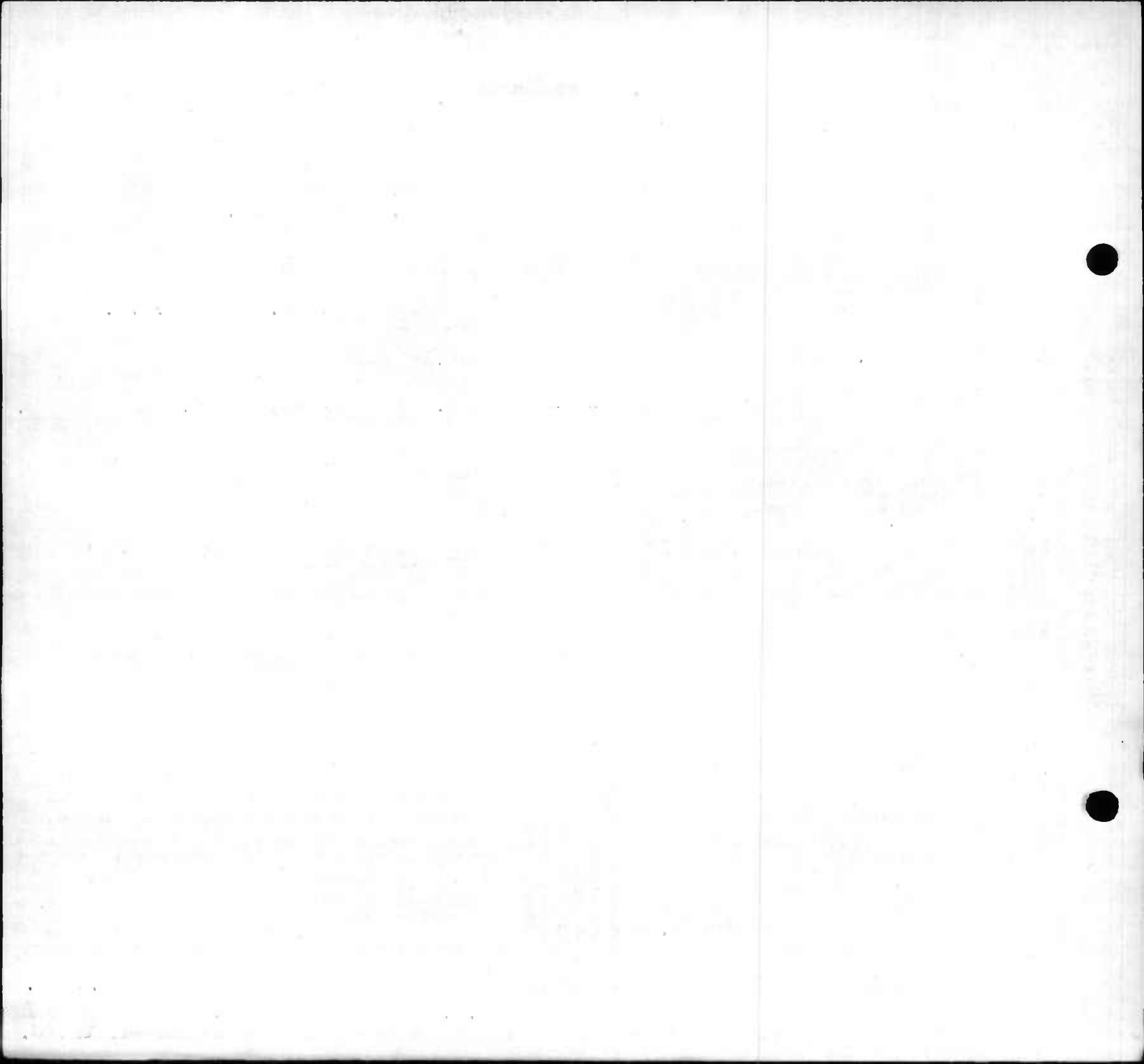
WALTER GEORGE

George M. M. M.

Approval of Med. Examiner
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04039		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04039	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Guy H. Mehlhorn		2. DATE AND HOUR OF DEATH April 19, 1966 2:30 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 202 S. Conkling St.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 4/23/1914	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10B. KIND OF BUSINESS OR INDUSTRY Dry Cleaning Plant		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Guy P. Melhorn		14. MOTHER'S MAIDEN NAME Nettie Hunt			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 220-14-3154		17. INFORMANT Mrs. Ethel Fifer, 202 S. Conkling St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <u>Crown Thrombosis</u> (B) <u>Out Sch - C.V. disease</u> (C) <u>Ribetes Malleola</u> INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 19 1966 to 4/12 1966, that (I) (we) lost saw the deceased alive on 4/12 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Julius H. Goodman		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/20/66	
23C. PHYSICIAN'S NAME (Type) Julius H. Goodman		23D. ADDRESS 3400 E. Balto St. Balto 24 Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/23/1966		24C. NAME OF CEMETERY or CREMATORY Mountain View	
24D. LOCATION Hazelton		24E. LOCATION (City, town, or county) (State) Luzerne Co., Pa.			
25A. DATE REC'D BY HEALTH DEPT. APR 20 1966		25B. NAME OF REGISTRAR R. E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Baltimore, 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 04040					CERTIFICATE OF DEATH		Registered No. 66 04040		
BIRTH NO. M.E. CASE NO.					2. DATE AND HOUR OF DEATH 4-18-1966 1:45 P. M.				
1. NAME OF DECEASED (Type or Print) PAGANO, S. DONALD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 12				
					D. STREET ADDRESS (If rural, give location) 6807 Bellona Ave.				
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5/10/1895	9. AGE (In years lost birthday) 70	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10B. KIND OF BUSINESS OR INDUSTRY Beverages		13. FATHER'S NAME Donato Pagano			14. MOTHER'S MAIDEN NAME Concetta DeBernadetta	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-03-9179		17. INFORMANT Mrs. Margie L. Pagano			ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CARDIOVASCULAR COLLAPSE (B) GRAM NEGATIVE SEPTICEMIA (C) URINARY TRACT INFECTION					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (A) (this hospital) attended the deceased from FEB-27-1966 19 to 4-18 19 66, that (A) (we) last saw the deceased alive on 4-18 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Joseph Notarangelo					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 4-18-1966	
23C. PHYSICIAN'S NAME (Type) JOSEPH NOTARANGELO					23D. ADDRESS MERCY HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/21/1966		24C. NAME of CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 20 1966			25B. NAME OF REGISTRAR Robert E. Jenkins, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Baltol2, Md.				

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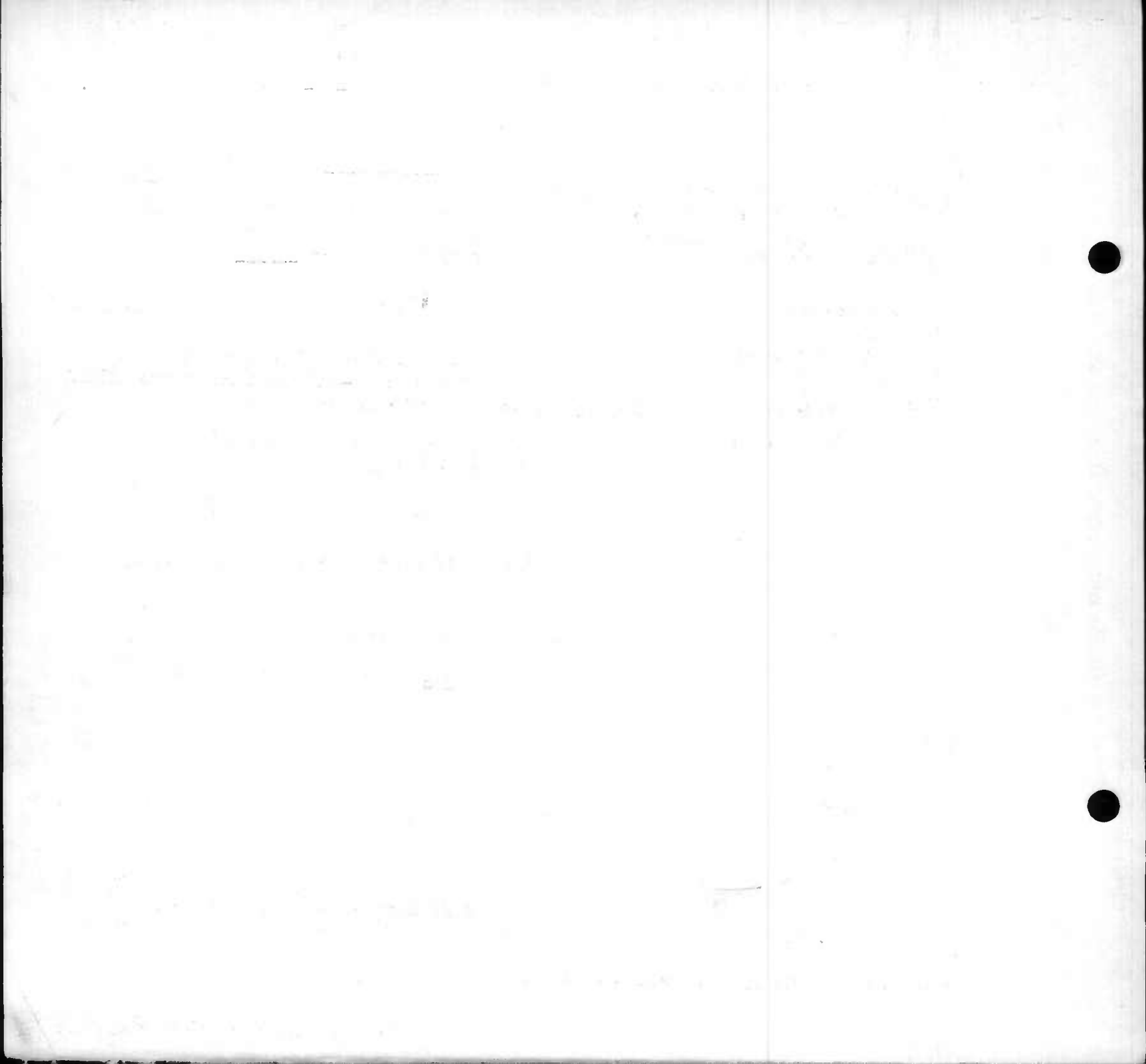
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04041	
BIRTH NO. 66 04041		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILLIAM W. LANE		2. DATE AND HOUR OF DEATH 4-18-1966 4:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BALTO CITY HOSP 4940 Eastern Avenue, Baltimore, Maryland		A. STATE MD. B. COUNTY BALTO			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO 53-00			
		D. STREET ADDRESS (If rural, give location) 810 I St. 21219			
5. SEX Male	6. RACE Negro	7. (MARRIED) NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 9-27-24	9. AGE (In years last birthday) 41 42
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOSEPH		14. MOTHER'S MAIDEN NAME LAURA BRYANT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 212-20-6020		17. INFORMANT Records: BCH-4940 Eastern Avenue 21224 Med Record.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 493 XI + 322.1 (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH CARDIAC ARREST RESPIRATORY		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO ANOXIA		(B) DUE TO PNEUMONIA - Prob Pneumococcal	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chr Alcoholism					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (If) (this hospital) attended the deceased from 4-17 19 66 to 4-18 19 66 , that (If) (we) last saw the deceased alive on 4-18 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If) (We) (did) (did not) view the body after death.			
23A. SIGNATURE J E Randall		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-18-66	
23C. PHYSICIAN'S NAME (Type) J. E. RANDALL		M.D. 4940 Eastern Avenue, Baltimore, Maryland BALTO City Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-22-66		24C. NAME OF CEMETERY OR CREMATORY Balto National	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 20 1966		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR H. Minton + D. [Signature]		25D. ADDRESS 1701 Laurens St			



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66 04042

BALTIMORE CITY HEALTH DEPARTMENT

66 04042

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Hunter Satterwhite

2. DATE AND HOUR PRONOUNCED DEAD

4/17/66

1:45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1345 Myrtle Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Divorced SEPARATED May 17, 1917

8. DATE OF BIRTH

9. AGE (In years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Construction

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Henderson, North Carolina U.S.A.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Ashton Satterwhite

14. MOTHER'S MAIDEN NAME

Elizabeth Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

240-03-0680

17. INFORMANT

ADDRESS

Mrs. Pearl Woods 1622N. Pulaski Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Bilateral bronchopneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Fatty alteration of liver

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

partial

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/18/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4-23-66

23C. NAME of CEMETERY or CREMATORY

Henderson

23D. LOCATION

(City, town, or county)

(State)

Henderson, North Carolina

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 20 1966

C. D. G. E. Johnson

The Morton and Dyett Funeral Home
1701 Laurens Street, Balto, Md. 21217

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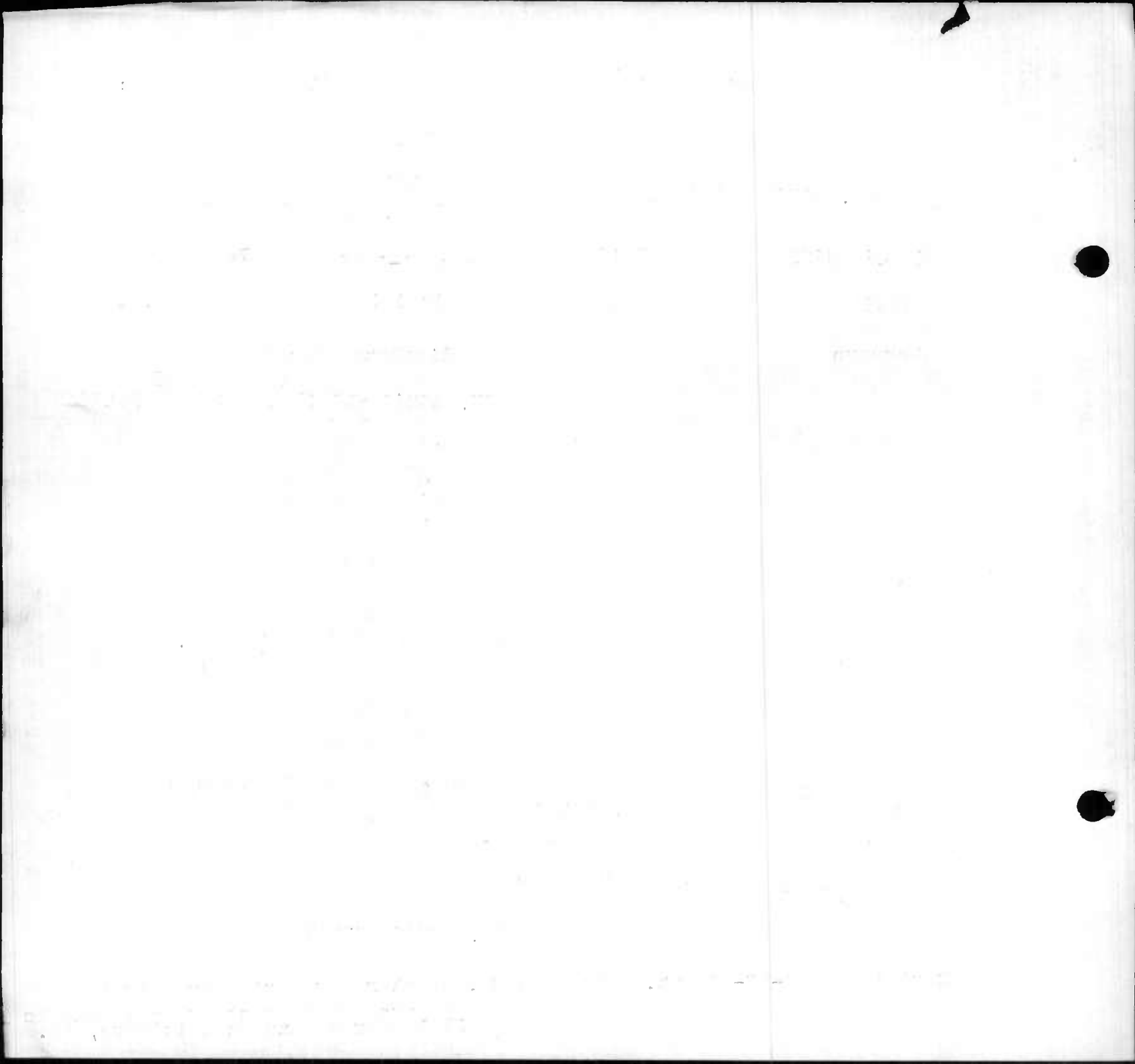
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04043		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04043	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FANNIE DUDLEY		2. DATE AND HOUR OF DEATH APRIL 18 1966 11:05 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 20-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 120 N. MONASTERY AVENUE			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH Sept 21-1895	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Elizabeth Chatman	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT AND CATON AVENUE ADDRESS ST. AGNES HOSPITAL RECORDS, WILKENS	
18. 490X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized atherosclerotic heart disease		CAUSE OF DEATH (A) Bilateral Pneumonia, Lung Abscess DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from MARCH 29 1966 to APRIL 18 1966 , that (X) (we) last saw the deceased alive on APRIL 18 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Winifredo N. Iglesias		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. ST. AGNES HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-23-66		24C. NAME OF CEMETERY or CREMATORY St. John Bapt Ch. Cemetery Frederickburg Virginia	
24D. LOCATION (City, town, or county) (State) 1701 Laurens Street Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 20 1966		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR ADDRESS The Morton and Dyett Funeral Home Inc					



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G. 650

66 04044

BALTIMORE CITY HEALTH DEPARTMENT

66 04044

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES GREEN

2. DATE AND HOUR PRONOUNCED DEAD

April 19, 1966 1:54 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

S. Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2313 Hunter St.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

8-9-1912

9. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

L

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VA

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Christine Green -832 Hanover St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic and hypertensive cardiovascular
disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenacker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-20-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4-23-66

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore City

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 21 1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Isaiah L. Brown and Son

ADDRESS

108 W. Montgomery Street

WALLLEY FORD

Unknown

9-9-1918

VA

Unknown

Charlotte Green - 832 Hanover St.

Serial 4-23-28
Lt Auburn Cemetery Baltimore, Md
Isiah L. Brown and Son
108 W. Montgomery Street

1
y-520

66 04045

BALTIMORE CITY HEALTH DEPARTMENT

66 04045

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM YOUNG

2. DATE AND HOUR PRONOUNCED DEAD

April 15, 1966 2:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

33 W. Lee Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

4 29 1934

9. AGE (In years
last birthday)

31

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William A. Young

14. MOTHER'S MAIDEN NAME

Mildered Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Esteele Jones 221 N. Broadway

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Fatty Degeneration of Liver.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐

NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED
4/15/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4-2-66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary

23D. LOCATION

(City, town, or county)

(State)

A.A.CO., MD

24A. DATE REC'D BY HEALTH DEPT.

APR 21 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Isaiah L. Brown and Son
108 W. Montgomery Street

ADDRESS

1934 2 28

D.C.

Missed Davis

Patricia Jones 221 N. Broadway

WILLIAM A. JONES

WILLIAM A. JONES

A.A.C.O., MD

W. A. JONES

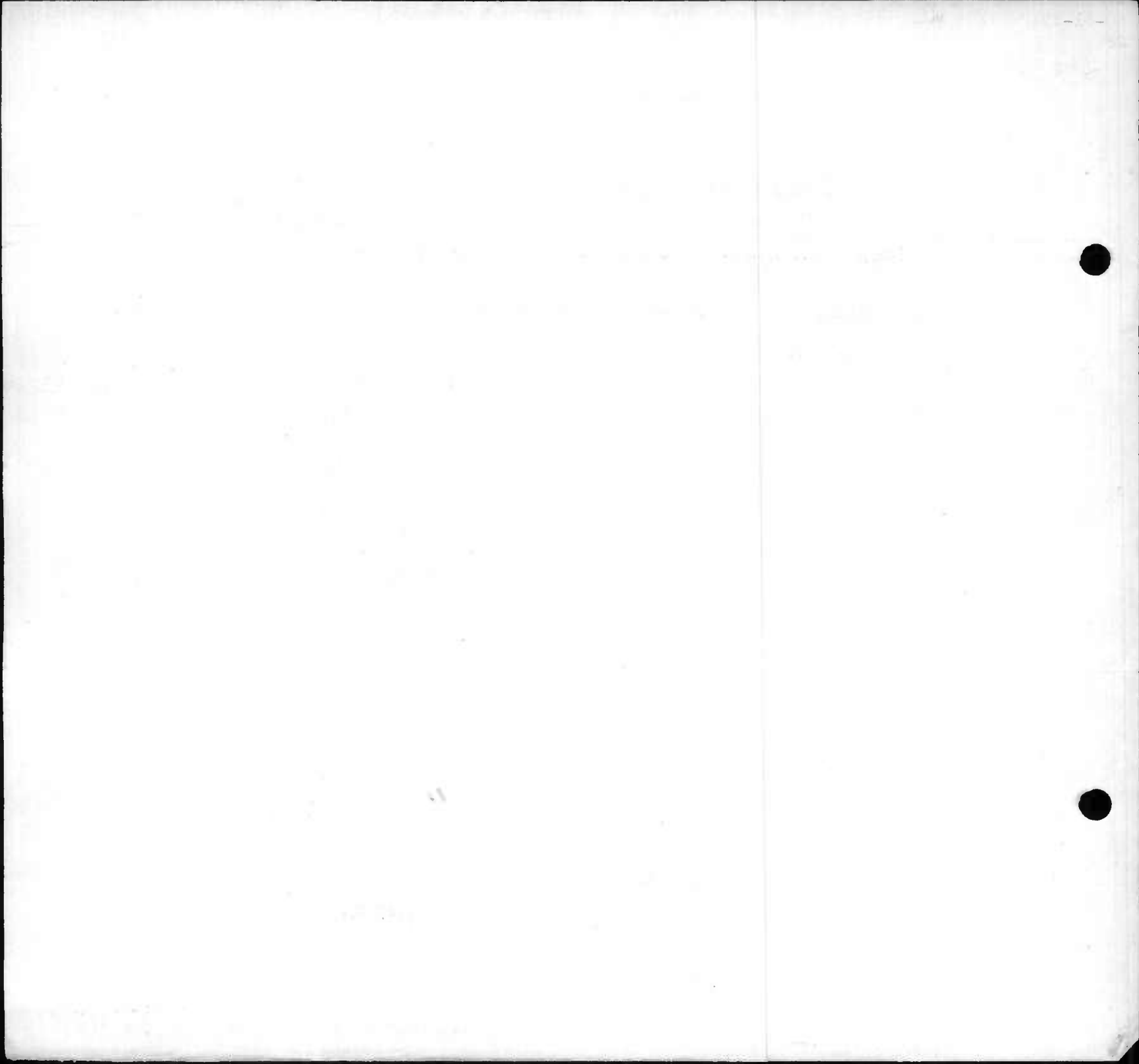
4-2-36

Noted

108 W. Montgomery Street
Lafayette, La.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04046	
BIRTH NO. K-500		66 04046		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mr. FRANK J. KUHN		2. DATE AND HOUR OF DEATH 4/17/66 12 30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE MD. B. COUNTY 26-07	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
BALTO. CITY HOS P. 4940 EASTERN AVENUE #21224		BALTIMORE		411 S. Lehigh St. #24	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 8-7-05	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY CONTINENTAL CAN CO.		11. BIRTHPLACE (State or foreign country) BALTO., MD.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ALOIS KUHN		14. MOTHER'S MAIDEN NAME CATHERINE WOLF	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-01-7794		BCH: RECORDS 4940 Eastern Avenue 21224 ADDRESS: MARGARET GURNEY A.A. SAME.	
18. 795701 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) ? Digitalis Toxicity (B) Iatrogenic (C) ? Pulmonary Embolus.		INTERVAL BETWEEN ONSET AND DEATH ? 1 day 3 ? 2 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Alcoholism; Lacunae's Cirrhosis. ASCVD; Emphysema; C.H.F.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work Not White At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/11 1966 to 4/17 1966 that (I) (we) last saw the deceased alive on 4/17 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE A. I. MURDOCK		M.D. Attending Phys. Med. Director Staff Phys. X		23B. DATE SIGNED 4/17/66	
23C. PHYSICIAN'S NAME (Type) A. I. MURDOCK		23D. ADDRESS 4940 EASTERN AVENUE #21224 Balto. City HOSPITALS.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-21-66		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.	
24D. LOCATION 7225 EASTERN BLVD. BALTO. CO., MD.		25A. DATE REC'D BY HEALTH DEPT. APR 21 1966		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Charles S. Zeiler		25D. ADDRESS 901 S. CONKLING ST. BALTO., 24, MD.			



66 04047

BALTIMORE CITY HEALTH DEPARTMENT

66 04047

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN Churchwell WOOLFREY

2. DATE AND HOUR PRONOUNCED DEAD

April 13, 1966 6:50 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1929 Fleet Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

2-8-1908 58

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Laborer

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Woolfrey

14. MOTHER'S MAIDEN NAME

Annie Minnick

15. WAS DECEASED EVER IN U.S. ARMED FORCES
(Yes, no or unknown) (If yes, give war or dates of service)

unknown

16. SOCIAL
SECURITY NO.

223-22-0506

17. INFORMANT

Hall Funeral Home

ADDRESS

Arlington, Virginia

18. 420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/14/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

4/14/66

23C. NAME OF CEMETERY or CREMATORY

Hall Funeral Home

23D. LOCATION

(City, town, or county)

(State)

Arlington - Virginia

24A. DATE REC'D BY HEALTH DEPT.

APR 21 1966

24B. NAME OF REGISTRAR

R. E. Finkley, M.D.

24C. FUNERAL DIRECTOR

Earl B. Woberton, Funeral Home Inc.
6306 - Belair Rd - Baltimore 66, Md

WALLLEY FORT

RECEIVED

1864

1864

WALLLEY FORT

1864

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

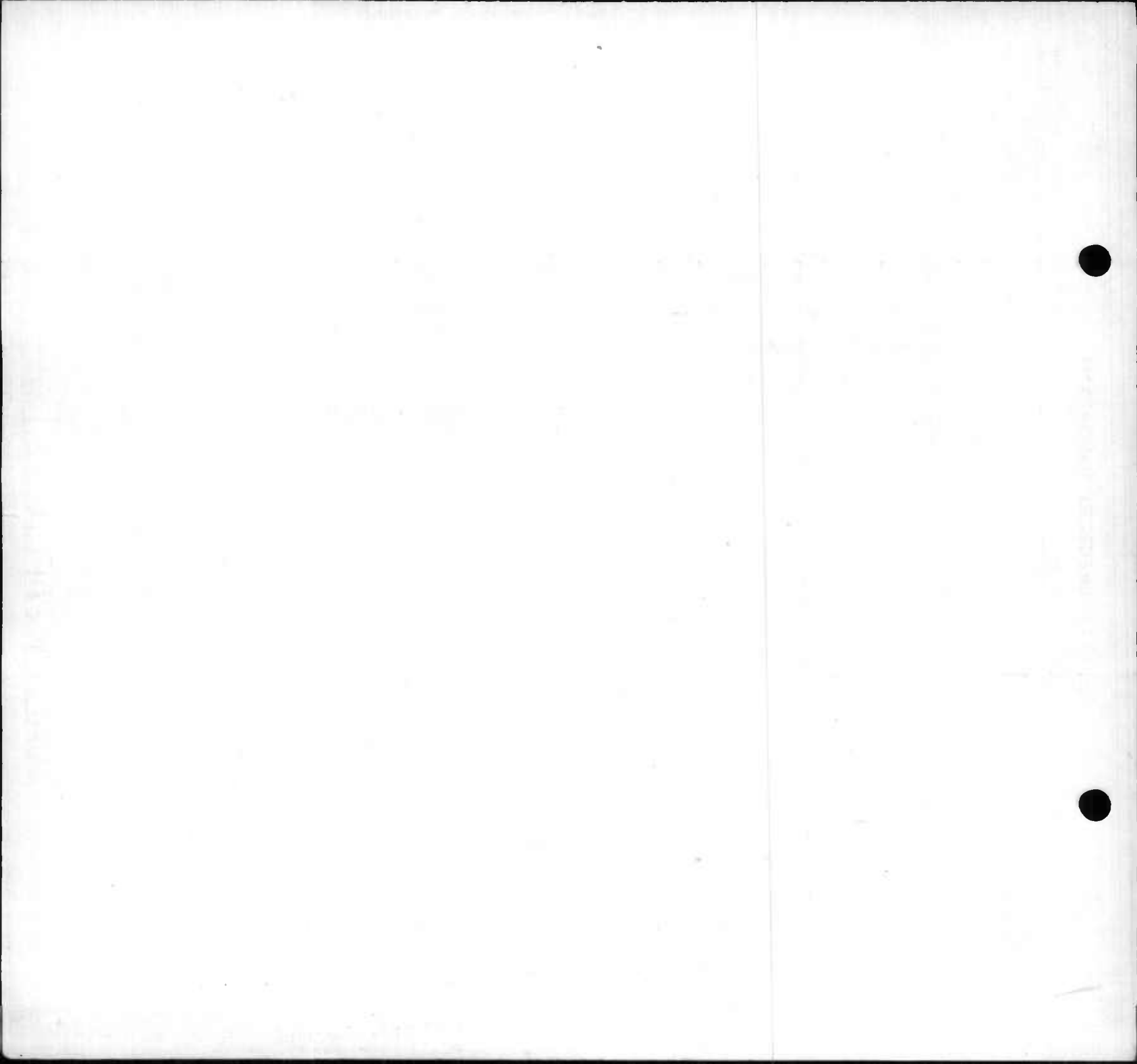
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No.			
M.E. CASE NO.				CERTIFICATE OF DEATH				66 04048			
1. NAME OF DECEASED (Type or Print) ELIZABETH V EHRMAN				2. DATE AND HOUR OF DEATH APRIL 18, 1966				5:00P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 28-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4632 COLEHERNE ROAD							
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 2-20-83	9. AGE (In years lost birthday) 83	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MEXICO IRELAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME MARTIN TIERNAN				14. MOTHER'S MAIDEN NAME BRIDGET MCNALE							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. ---		17. INFORMANT ST. AGNES HOSPITAL RECORDS - WILKENS					
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) INTRA CEREBRAL HEMORRHAGE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH Intra cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 4 hours							
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 18, 1966 to APRIL 18, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 18, 1966 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (do not) view the body after death.											
23A. SIGNATURE <i>Stapher. by date no</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 18 Apr 66			
23C. PHYSICIAN'S NAME (Type) <i>Ralph Updike</i>				M.D. 23D. ADDRESS ST. AGNES HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-22-66		24C. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. APR 21 1966				25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>Harry - Canavan</i>		ADDRESS <i>11601 Fiddlers</i>			

ОБЩЕСТВЕННЫЙ ЗАКАЗ

FUNERAL DIRECTOR: IMPORTANT

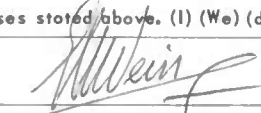
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

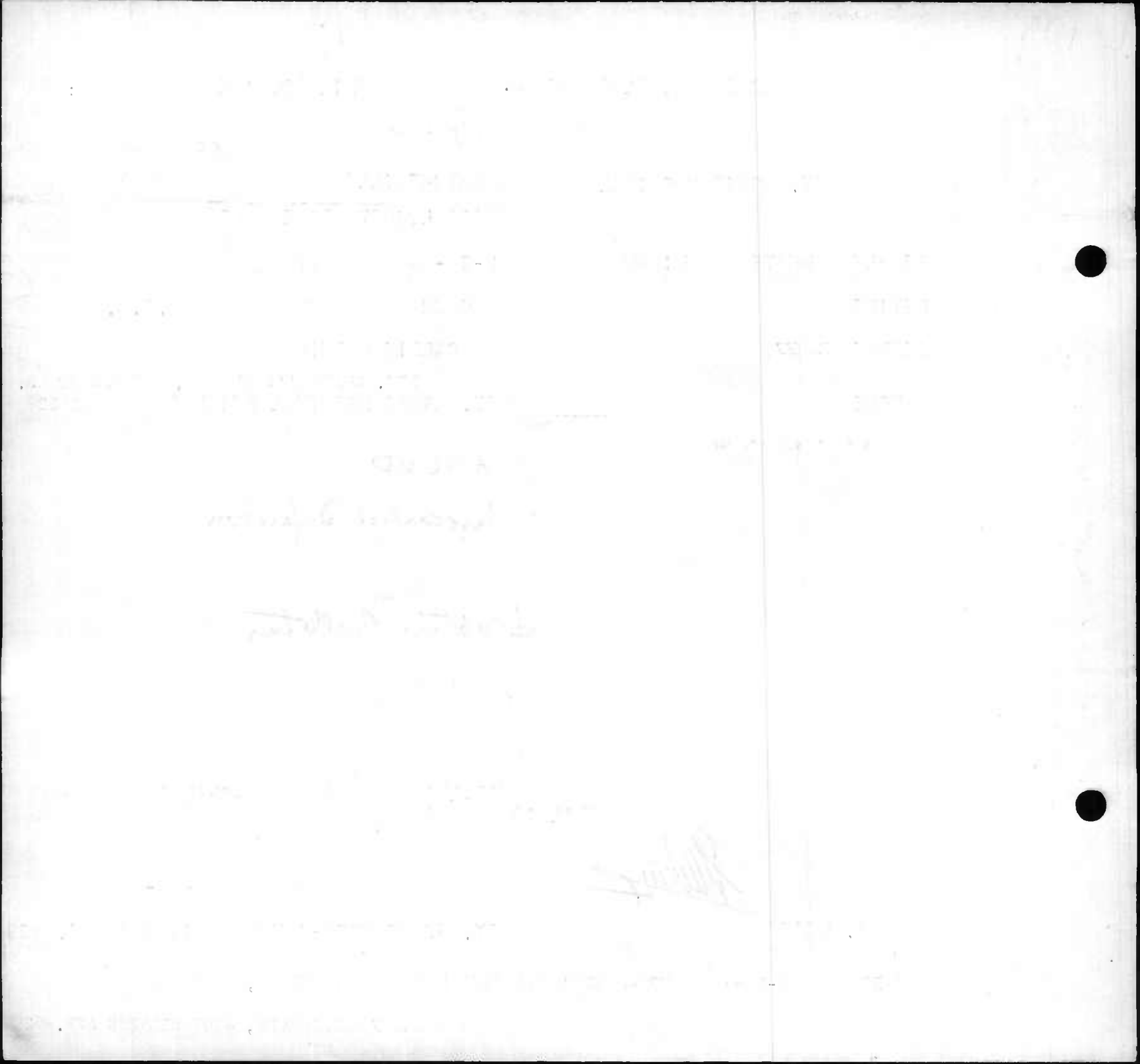
BIRTH NO. 66 04049		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04049	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Alice May Rumens		2. DATE AND HOUR OF DEATH April 17, 1966 1 6 p M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 308 E. 28 Street Baltimore, Md. 21218		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 308 E. 28 Street			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH May 22, 1884	9. AGE (In years last birthday) 81	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel Glendinning		14. MOTHER'S MAIDEN NAME Eleanor Ann Jefferson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-2829		17. INFORMANT George J. Rumens (Husband)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) DUE TO Cardiovascular Renal Disease (B) DUE TO Generalized Arteriosclerosis (C) DUE TO Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH Indefinite Indefinite Indefinite	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 19 65 to April 17 19 65, that (I) (we) last saw the deceased alive on April 17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nathaniel M. Beck		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED April 19-66	
23C. PHYSICIAN'S NAME (Type) Nathaniel M. Beck		23D. ADDRESS M.D. 2818 St. Paul Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/20/1966		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. APR 21 1966		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Eugenia K. Seitz	
25D. ADDRESS 5209 York Road		Baltimore, Maryland			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04050	
BIRTH NO. 66 04050		CERTIFICATE OF DEATH			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		LIPSCOMB, FLORENCE A.		2. DATE AND HOUR OF DEATH APRIL 19, 1966 9:55A.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) CATONSVILLE			
		D. STREET ADDRESS (If rural, give location) 111 LOCUST DRIVE #28			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 8-27-88	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CONN	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE RUOFF		14. MOTHER'S MAIDEN NAME CARRIE MARVIN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. CHARLOTTE STEVENS, 111 LOCUST DR. ST. AGNES HOSPITAL RECORDS 21228	
18. 420.1x1-260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCVD ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocardial Infarction		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from APRIL 16 1966 to APRIL 19 1966 , that (I) (we) last saw the deceased alive on APRIL 19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-19-66	
23C. PHYSICIAN'S NAME (Type) E. WEISS		23D. ADDRESS M.O. ST. AGNES HOSP; CATON & WILKENS AVE. #29			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-22-66		24C. NAME OF CEMETERY or CREMATORY MEADOWRIDGE MEMORIAL PARK	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. APR 21 1966		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR HUBBARD FUNERAL HOME, 4107 WILKENS AVE. #29		25D. ADDRESS			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04051

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

John Garber, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

4/18/66 8:15 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Pier 4 - Pratt St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1316 Bonsal Street

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED

8. DATE OF BIRTH

JUNE 30, 1928

9. AGE (In years
last birthday)

37

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MERCHANT SEAMAN

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

OHIO

12. CITIZEN OF
WHAT COUNTRY?
US.A.

13. FATHER'S NAME

CLARENCE CHARLES

14. MOTHER'S MAIDEN NAME

CARMIN WARNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

KOREAN

16. SOCIAL
SECURITY NO.

300-20-1411

17. INFORMANT

ADDRESS

MRS. EVELYN GARBEN, 1316 BONSAI ST. APT. T-3

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Drowning
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

water

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

found - Pier 4-Pratt St.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
4 ? 66 ?

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

undetermined - found in water

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/19/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

4-20-66

23C. NAME OF CEMETERY or CREMATORY

NEY CEMETERY

23D. LOCATION

(City, town, or county)

(State)

NEY, OHIO

24A. DATE REC'D BY HEALTH DEPT.

APR 21 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

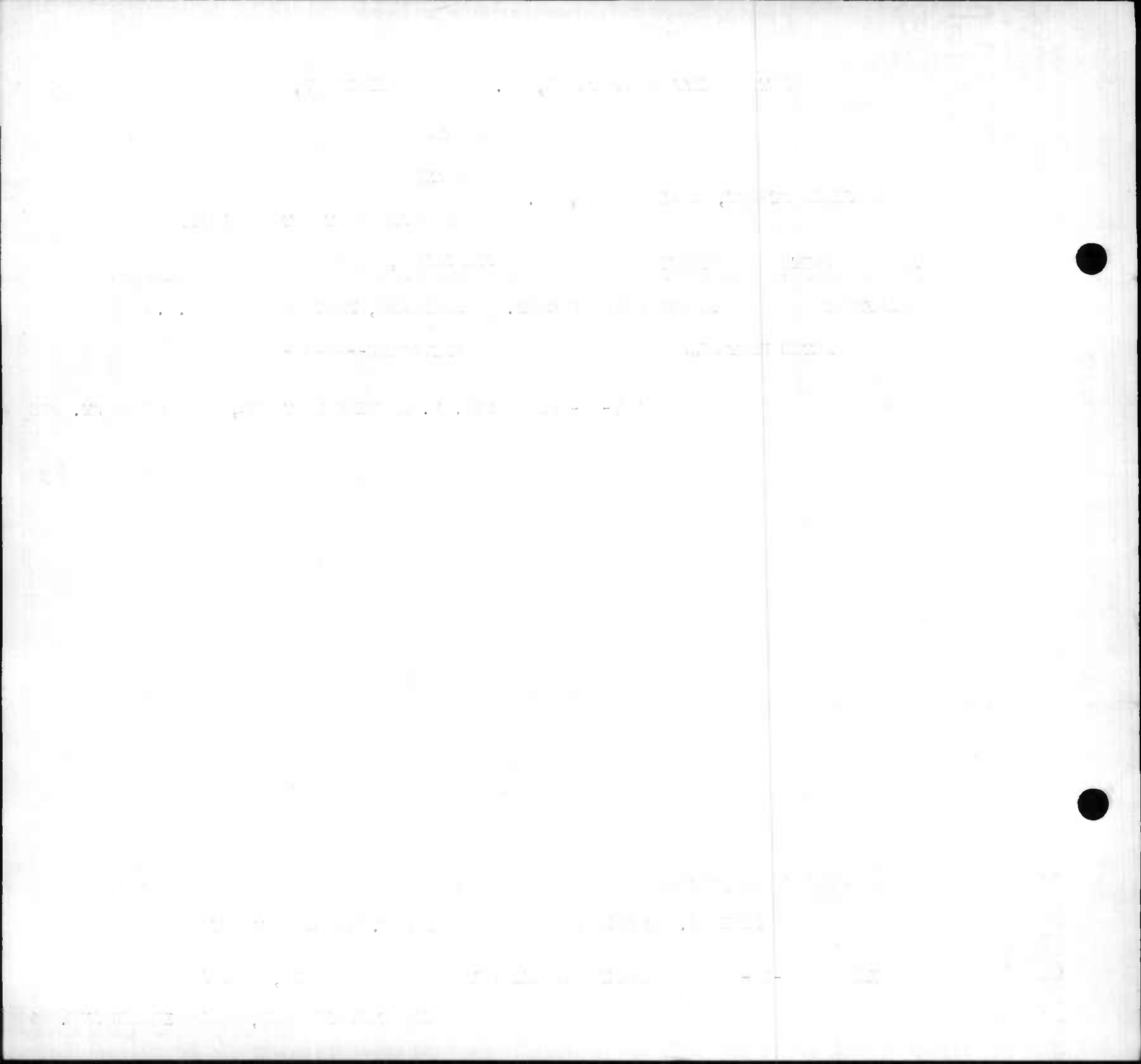
ADDRESS

HUBBARD FUNERAL HOME, 4107 WILKENS AVE. #29

WALLLEY & PUGH

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

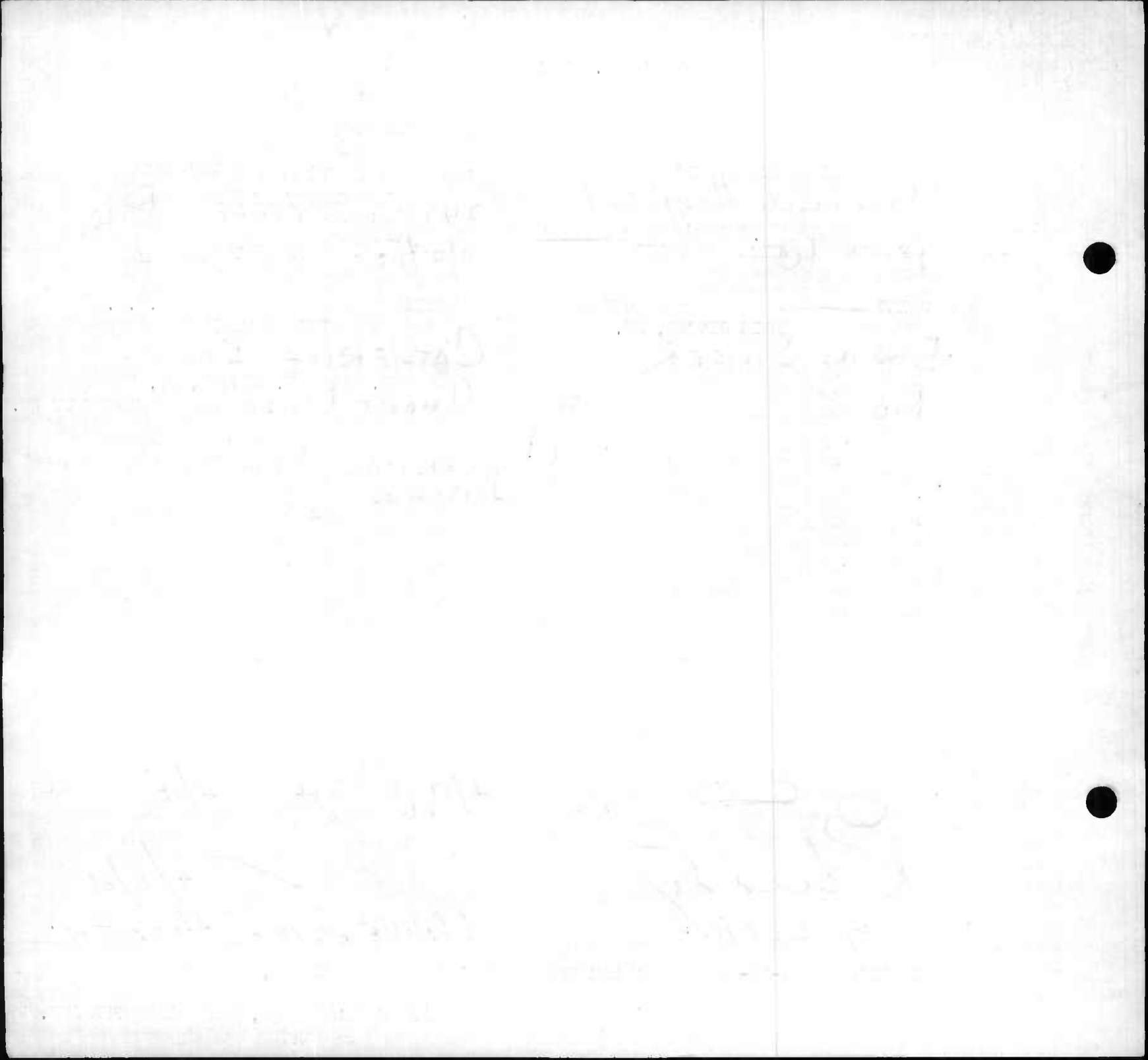
BIRTH NO. 66 04052		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04052	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		WALTER CLIFFORD HARTZELL, SR.		2. DATE AND HOUR OF DEATH APRIL 17, 1966 5A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 1314 JAMES STREET, BALTIMORE 23, MD.		A. STATE MARYLAND		B. COUNTY 2102	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
		D. STREET ADDRESS (If rural, give location)		1314 JAMES STREET 21223	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH JANUARY 8, 1900	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		10B. KIND OF BUSINESS OR INDUSTRY ARUNDEL BROOKS CORP.		11. BIRTHPLACE (State or foreign country) ABERDEEN, MARYLAND	
13. FATHER'S NAME WALTER HARTZELL		14. MOTHER'S MAIDEN NAME CATHERINE-----		12. CITIZEN OF WHAT COUNTRY? U.S.A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-09-3933		17. INFORMANT MRS. E. PAULINE HARTZELL, 1314 JAMES ST. #23	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.11 CORONARY THROMBOSIS		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Since Feb. 1963	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 5, 1965 to April 17, 1966, that (I) (we) last saw the deceased alive on April 16, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Morris B. Schreiber		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4-19-66	
23C. PHYSICIAN'S NAME (Type) MORRIS B. SCHREIBER		23D. ADDRESS M.D. 1519 W. LOMBARD STREET			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-20-66		24C. NAME OF CEMETERY or CREMATORY BEL AIR MEMORIAL GARDENS	
				24D. LOCATION (City, town, or county) (State) BEL AIR, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1966		25B. NAME OF REGISTRAR R. E. Fisher		25C. FUNERAL DIRECTOR HUBBARD FUNERAL HOME, 4107 GILKENS AVE. #29	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

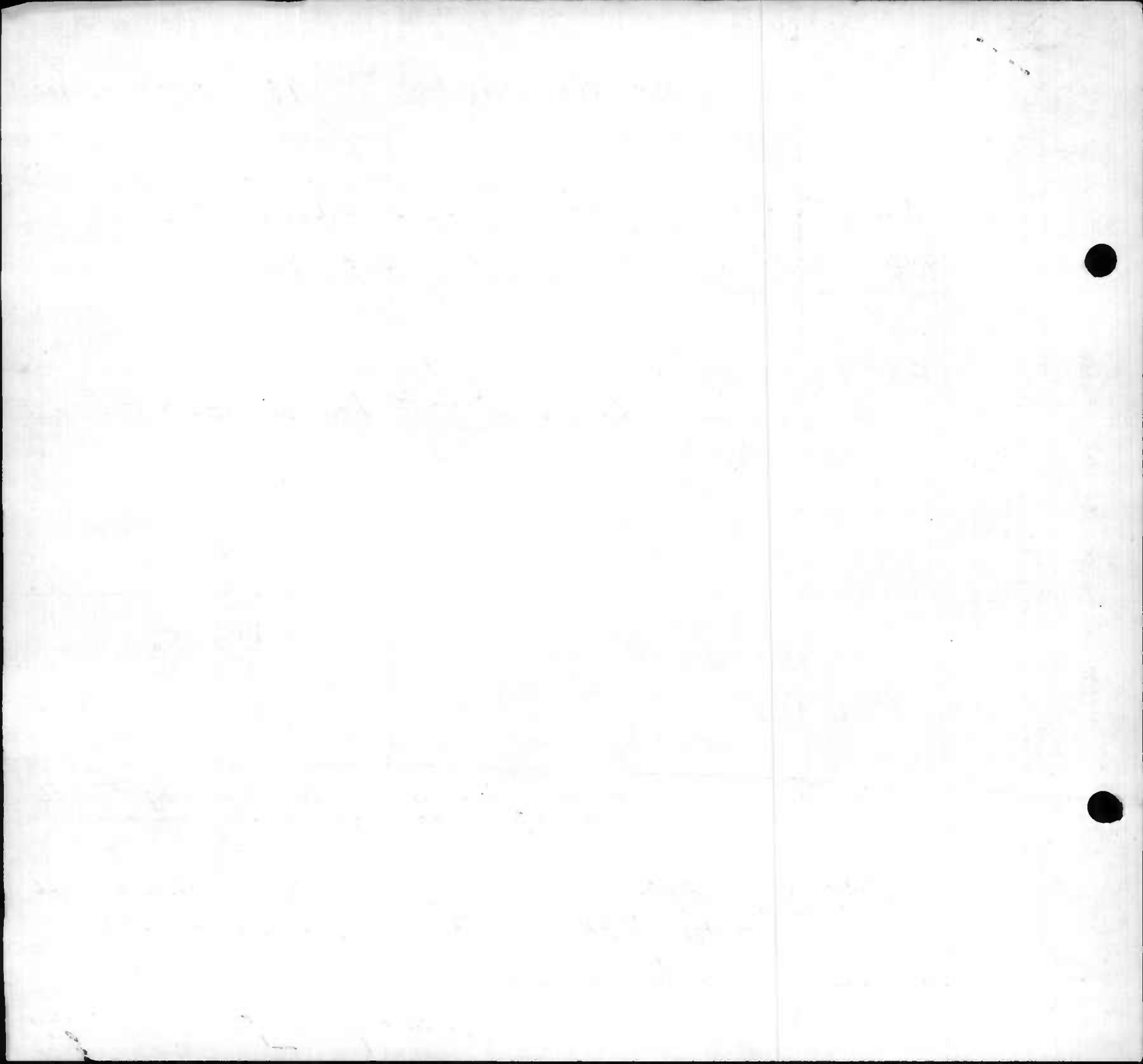
BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH											
Registered No. 66-04053											
BIRTH NO. 66-07182 66 04053											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) BERNADETTE G. SINTER						2. DATE AND HOUR OF DEATH 4/18/66 11:00 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL <i>University Hospital</i>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) REISTERSTOWN D. STREET ADDRESS (If rural, give location) 249 CANDYTUFT ROAD <i>RD</i>					
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED CHILD		8. DATE OF BIRTH 4/4/66		9. AGE (In years last birthday) XX 14 Days		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD				10B. KIND OF BUSINESS OR INDUSTRY CHILD				11. BIRTHPLACE (State or foreign country) MARYLAND			
13. FATHER'S NAME EDWIN SINGER, JR. <i>EDWIN SINGER</i>						14. MOTHER'S MAIDEN NAME CATHERINE DORSEY <i>CATHERINE DORSEY</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. CHILD		17. INFORMANT MR. EDWIN F. SINGER, JR. 249 CANDYTUFT RD.					
18. 75-4-51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGENITAL HEART DISEASE CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH BIRTH											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/17 19 66 to 4/18 19 66 , that (I) (we) last saw the deceased alive on 4/18 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>[Signature]</i>								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/18/66	
23C. PHYSICIAN'S NAME (Type) R. LUDDY								23D. ADDRESS M.D. UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 4-21-66		24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL CEMETERY				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1966				25B. NAME OF REGISTRAR <i>[Signature]</i>				25C. FUNERAL DIRECTOR HUBBARD FUNERAL HOME, 4107 WILKEN AVE. #29			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

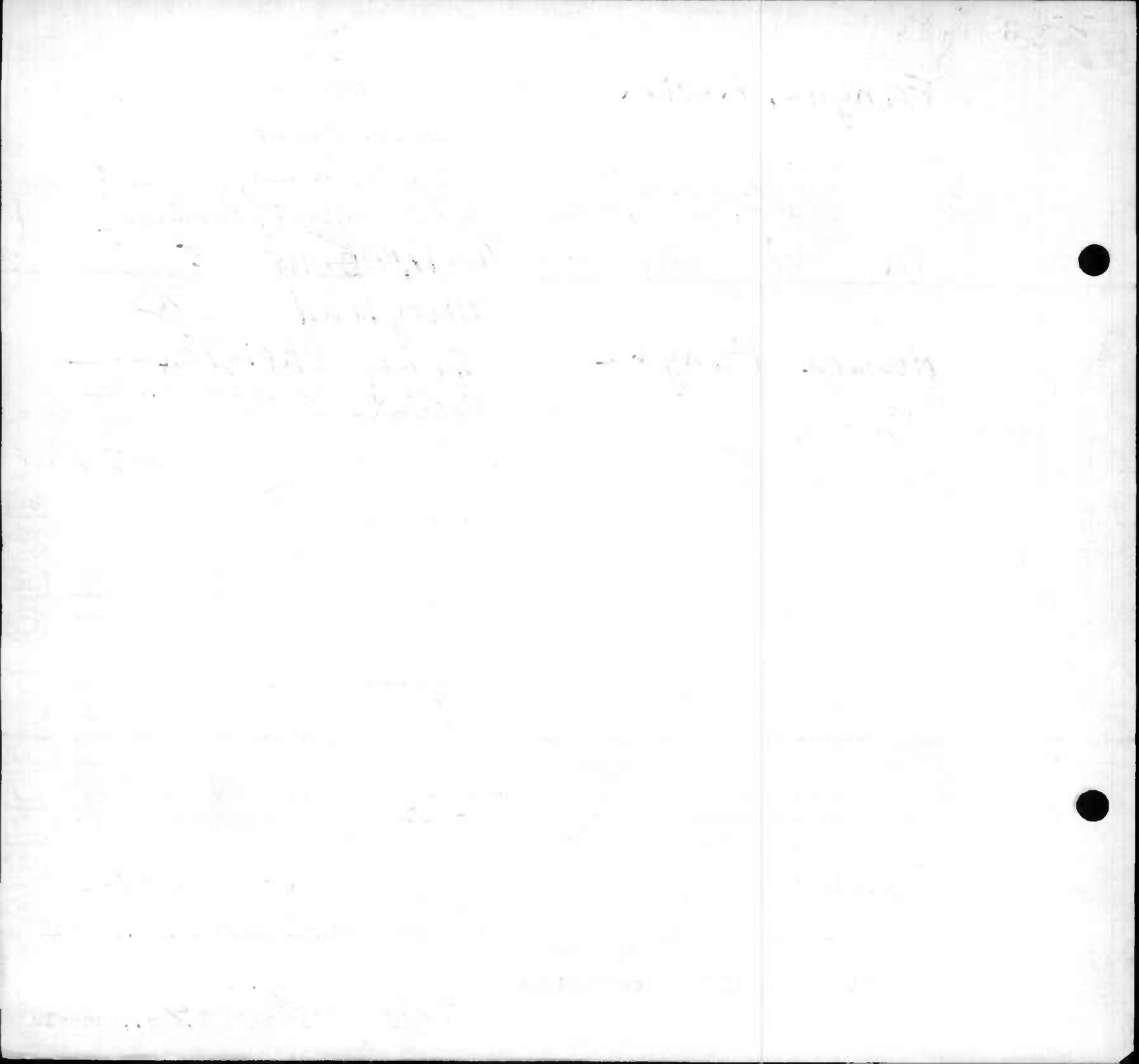
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>66 04054</u>	
BIRTH NO. <u>66 04054</u>							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <u>LOWMAN, IRA. WASHINGTON</u>		2. DATE AND HOUR OF DEATH <u>7⁴⁰ April - 19-1966</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>19-04</u>					
FULL NAME OF HOSPITAL OR INSTITUTION <u>Franklin Square Hospital</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 23</u>					
		D. STREET ADDRESS (If rural, give location) <u>132 S. Gilmore St.</u>					
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>1-31-1954</u>	9. AGE (In years last birthday) <u>8-2</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212 09 8762</u>		17. INFORMANT <u>Janie E. Lowman</u>		ADDRESS <u>132 S. Gilmore St</u>	
18. <u>331 X I</u>		CAUSE OF DEATH <u>C. T. A.</u>				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3-21</u> 19 <u>66</u> to <u>4-19</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4-17</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Jong-Hi Bek</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4-17-1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>JONG-HI BEK</u>				23D. ADDRESS <u>Franklin Square Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/20/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>LOUDON PARK Cem</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, MA</u>		25C. FUNERAL DIRECTOR <u>Thomas J. Kenney Inc</u>		ADDRESS <u>1600 Hollis</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

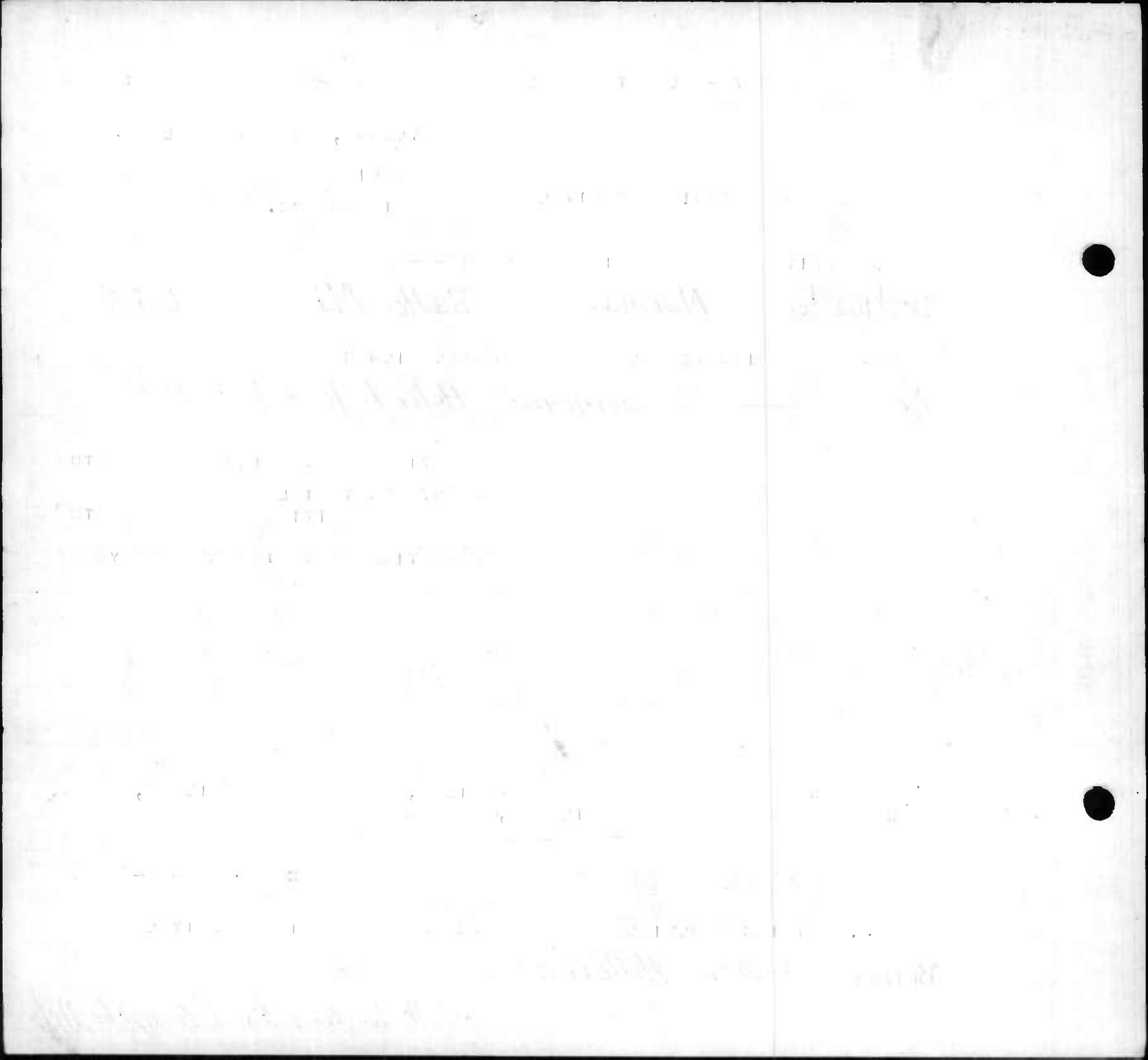
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 14055	
BIRTH NO. 65-2853466 04055				1. NAME OF DECEASED (Type or Print) Fangue, Kevin Joseph		2. DATE AND HOUR OF DEATH 4/19/66 5:10 P. M.	
M.E. CASE NO.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland, Baltimore B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland, #21224				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 2729 Liberty Parkway	
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married		8. DATE OF BIRTH Nov 17, 1965 (In Years, Months, Days)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Howard Fangue				14. MOTHER'S MAIDEN NAME Nancy Christensen			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT RECORDS: BCH, 4940 Eastern Ave., #21224 Parents	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 762.01 Aspiration				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH ~ 7 hr	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(A) DUE TO		(B) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-19-66 to 4-19-66 and that (I) (we) last saw the deceased alive on 4-19-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Herbert Kaizer		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-19-66	
23C. PHYSICIAN'S NAME (Type) DR. HERBERT KAIZER		23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md., #21224		M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/21/66		24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial		24D. LOCATION (City, town, or county) (State) Dorsey, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1966		25B. NAME OF REGISTRAR Walter Brooks Bradley		25C. FUNERAL DIRECTOR Walter Brooks Bradley		ADDRESS Ind., Dundalk	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 04056 CERTIFICATE OF DEATH					Registered No. 66 04056				
BIRTH NO. M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH				
		ERNEST + ALBERT TEUFEL			4-17-66			7:30 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL					A. STATE MARYLAND, ANNE ARUNDEL				
					B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					ANNAPOLIS				
					D. STREET ADDRESS (If rural, give location)				
					104 LINDEN AVE.				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	11. Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
MALE	WHITE	MARRIED		11-3-23	42				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Dockmaster		Marina			Balto. Md.		USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
JOHN FREDERICK TEUFEL					MABEL GILMAN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				219-10-1225		Helen L. Tuefel		#4	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO			CONGESTIVE HEART FAILURE 1 MONTH	
					(B) DUE TO			SUB-ACUTE BACTERIAL ENDOCARDITIS 1 MONTH	
					(C) DUE TO			RHEUMATIC HEART DISEASE 35 YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2					YES				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (M) (this hospital) attended the deceased from APRIL 5, 19 66 to APRIL 17, 19 66, that (X) (we) lost saw the deceased alive on APRIL 17, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE								23B. DATE SIGNED	
J. Patrick Caulfield M.D.								4-17-66	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
J. PATRICK CAULFIELD					THE JOHNS HOPKINS HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		4-21-66		Hillcrest		Annapolis Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			ADDRESS	
APR 21 1966		Robert E. Taylor, M.D.			John M. Taylor & Son			Annapolis, Md.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

IDA MAE MARTIN

2. DATE AND HOUR PRONOUNCED DEAD

15 April 1966 11:30 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland Anne Arundel

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Annapolis

D. STREET ADDRESS (If rural, give location)

36 Monroe Ct.

5. SEX

female

6. RACE

caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

June 2, 1903

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Ret.

10B. KIND OF BUSINESS OR INDUSTRY

P.B.X. operator

11. BIRTHPLACE (State or foreign country)

W. Va.

12. CITIZEN OF
WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

SAMUEL MARTIN

14. MOTHER'S MAIDEN NAME

Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

J. RICHARDSON

ADDRESS
913 LOVENTREE RD.
ELLIOTT CITY, MD.18. 422.1 + 2816.4
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Arteriosclerotic cardiovascular disease
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATHII
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.fracture of cervical spine with compression
of cervical spinal cord

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING TO CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

US 301 1 mile south of Rt. 450

21D. TIME
OF INJURY
(APPROX.)

April 9 1966 5:00 p.m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

passenger in auto-auto collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

C. Lewis & Kelly

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/16/66

23A. BURIAL, CREMATION,
REMOVAL (specify)

Burial

23B. DATE

4-18-66

23C. NAME OF CEMETERY or CREMATORY

Hillcrest

23D. LOCATION

(City, town, or county)

Annapolis

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 21 1966 P. E. E. F. E. M. D.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

John M. Taylor & Sons

ADDRESS

Annapolis, Md.

June 2, 1963

"Unit"

Thompson

Martin

Samuel

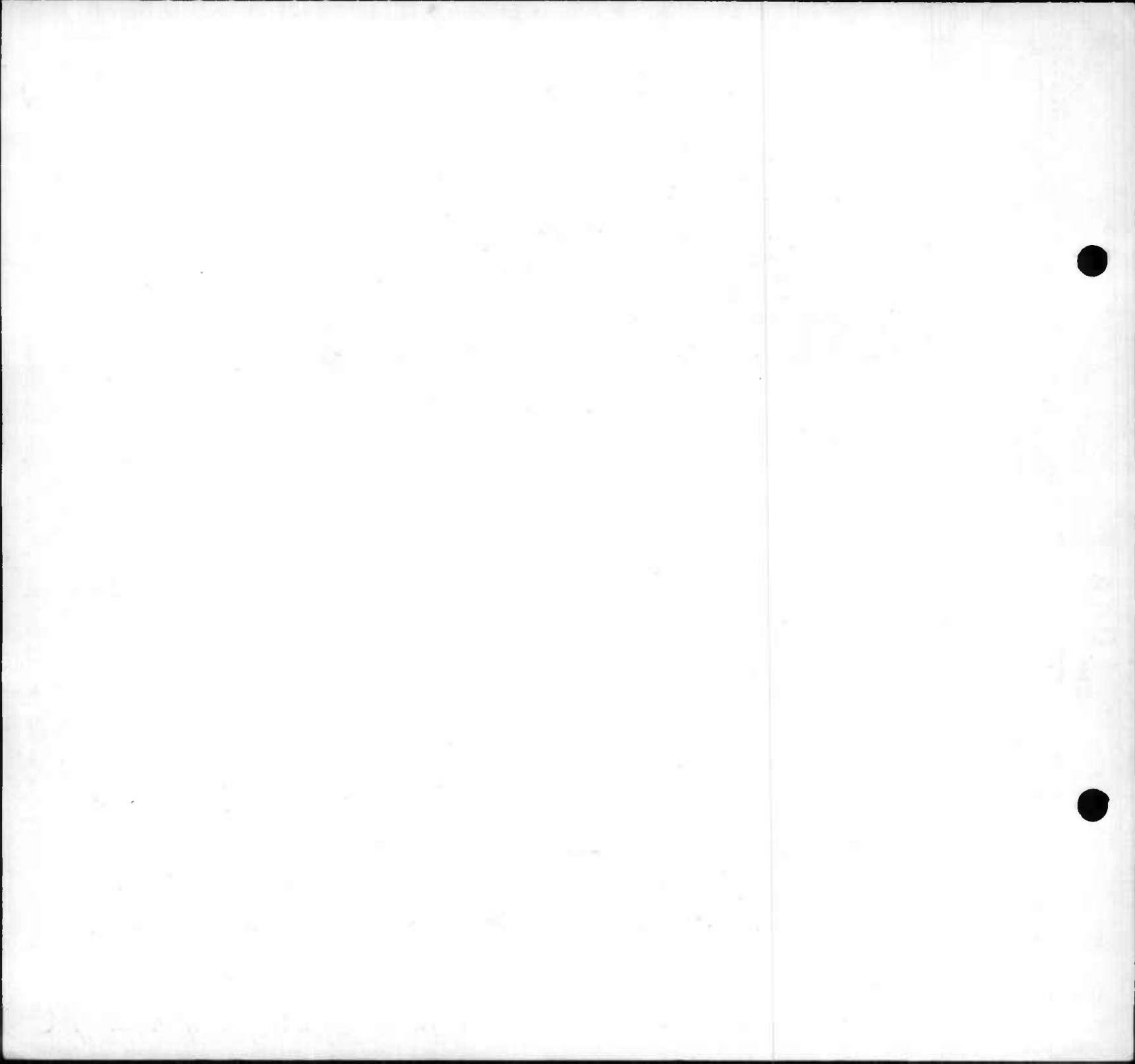
1-10-66 West

Amesbury

John M. Thompson
1-10-66

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04058	
BIRTH NO. 66 04058		CERTIFICATE OF DEATH			
M.E. CASE NO. 66 04058					
1. NAME OF DECEASED (Type or Print) Kocher, Elizabeth M.		2. DATE AND HOUR OF DEATH 4/19/66 4:40 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 91 Monte Sello State Hospital		A. STATE Maryland B. COUNTY 9-04			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3030 MacArthur St.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 6/22/1900	9. AGE (In years last birthday) 65	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles H. Proctor		14. MOTHER'S MAIDEN NAME Margaret M. Miller	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-03-1845 B		17. INFORMANT ADDRESS Hospital Records.	
18. 332X1		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Cerebral thrombosis - rt. hemiplegia + aphasia		1 1/2 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) gen. arteriosclerosis		unknown	
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/9/64 19 to 4/19/66 19, that (I) (we) last saw the deceased alive on 4/19/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel F. Lai		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/19/66	
23C. PHYSICIAN'S NAME (Type) DANIEL F. LAI		23D. ADDRESS 2201 Argonne Drive, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-22-1966		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. APR 21 1966		25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR ADDRESS Eugene M. Seitz 5209 York Rd. Seitz Funeral Home Balt., Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No.			
M.E. CASE NO.				66 04059				66 04059			
1. NAME OF DECEASED (Type or Print)				GARRETTSON Walter H.				2. DATE AND HOUR OF DEATH 4/18/66 8:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				Md. Anne Arundel							
University Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township)				GLEN BURNIE 52-00			
				D. STREET ADDRESS (If rural, give location)				Rt. 2 Box 500			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 6/7/99	9. AGE (If years lost birthday)	66	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Tavern owner				Self-Emp.				Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
SERALD GARRETTSON				CLARA BOLTON				USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
No				Unknown				Herbert GARRETTSON - GRAYSONVILLE Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
331X11-131X				CVA							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Bilateral Pneumonia							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
4/6/66 - 4/13/66				Carcinoma stomach				Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/30/66 1966 to 4/18 1966, that (I) (we) last saw the deceased alive on 4/18 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
Francisco M. SanDiford M.D.				4/18/66							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
Francisco M. SanDiford M.D.				University Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME of CEMETERY or CREMATORY			
Burial				Apr. 22, 1966				Glen Haven Mem. Park			
24D. LOCATION (City, town, or county) (State)				24E. LOCATION (City, town, or county) (State)				24F. LOCATION (City, town, or county) (State)			
Glen Burnie, Maryland				Glen Burnie, Maryland				Glen Burnie, Maryland			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR			
APR 21 1966				Robert E. Fairbank				Richard V. Singleton			

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For the purpose of the
1871-1899

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 04060 CERTIFICATE OF DEATH					Registered No. 66 04060				
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				HERPEL, SR., GEORGE, WILLIAM		4-17-66		2:35 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL					A. STATE MARYLAND				
					B. COUNTY Anne Arundel				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) PASADENA				
					D. STREET ADDRESS (If rural, give location) RT. 10 BOX 147 LAKE SHORE DRIVE				
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 8-22-10	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC			10B. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME CHARLES Herbel					14. MOTHER'S MAIDEN NAME SELMA EVERSMEIR				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES U.S. ARMY WW II			16. SOCIAL SECURITY NO. 213-20-2668		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS WILKENS & CATON AVE. 21229				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH				
I 420.1 I PULMONARY EDEMA MYOCARDIAL INFARCTION									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DISSEMINATED LUPUS									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 4-17 1966 to 4-17 1966 that (I) (we) last saw the deceased alive on 4-17 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Wilkinson					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-17-66		
23C. PHYSICIAN'S NAME (Type) DR. MANFRED F. AMRHEIN					23D. ADDRESS ST. AGNES HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Apr. 20/66		24C. NAME OF CEMETERY or CREMATORY Glen Haven Mem. Park		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 21 1966		25B. NAME OF REGISTRAR Robert E. Farley, M.D.			25C. FUNERAL DIRECTOR R. K. Singleton Singleton Funeral Home Glen Burnie, Md.				

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1000 *Reviews*

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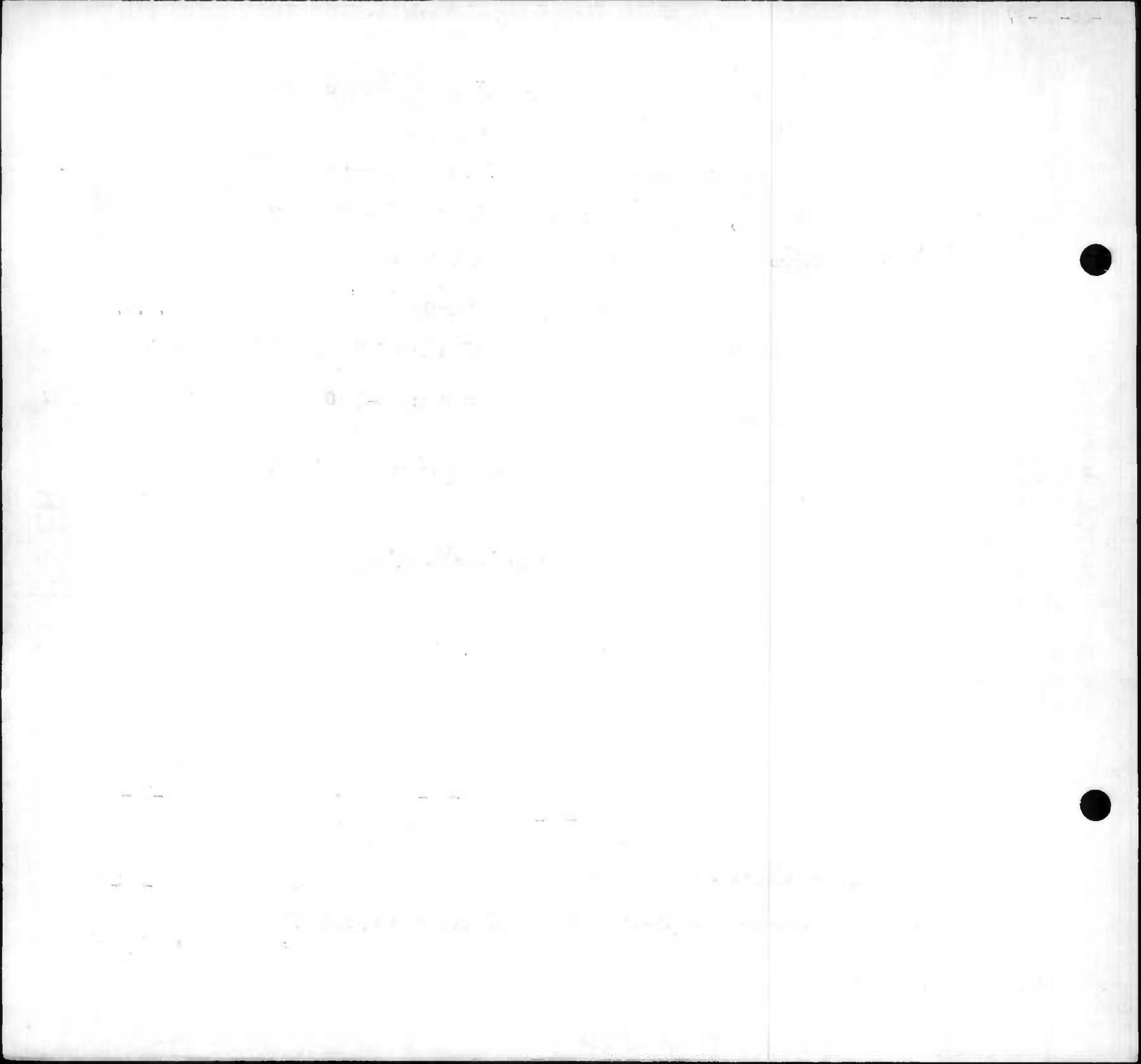
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04061 | |
|--|---------------|--|--------------------------|--|---|
| BIRTH NO. 66-07429 66 04061 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) COR BIN, BABY BOY Ernestine | | 2. DATE AND HOUR OF DEATH 4/16/66 3:25 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
BALTIMORE CITY HOSPITAL
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
2900 AUCHENTORLY TERRACE 21217 | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Never married | 8. DATE OF BIRTH 4/12/66 | 9. AGE (In years last birthday)
3 | If Under 1 Yr. Months: Days: Hours: Min.
If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Albert | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Records: BCH-4940
ADDRESS
Eastern Avenue 21224 | |
| 18. 773.51
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Respiratory Distress
(B) DUE TO
(C) Prematurity | | INTERVAL BETWEEN ONSET AND DEATH
3 days | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-12-19 66 to 4-16-19 66, that (I) (we) last saw the deceased alive on 4-16-19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
A. H. Mahsoob | | | | 23B. DATE SIGNED
4-16-66 | |
| 23C. PHYSICIAN'S NAME (Type)
ABDUL-NAMEH MAHSOOB | | | | 23D. ADDRESS
BALTIMORE CITY HOSPITAL
4940 Eastern Avenue, Baltimore, Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Cremation | | 24B. DATE
4-18-66 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore City Hospitals Baltimore, Maryland 21224 | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
A. L. E. Taylor | | 25C. FUNERAL DIRECTOR
HOSPITAL DISPOSAL | |

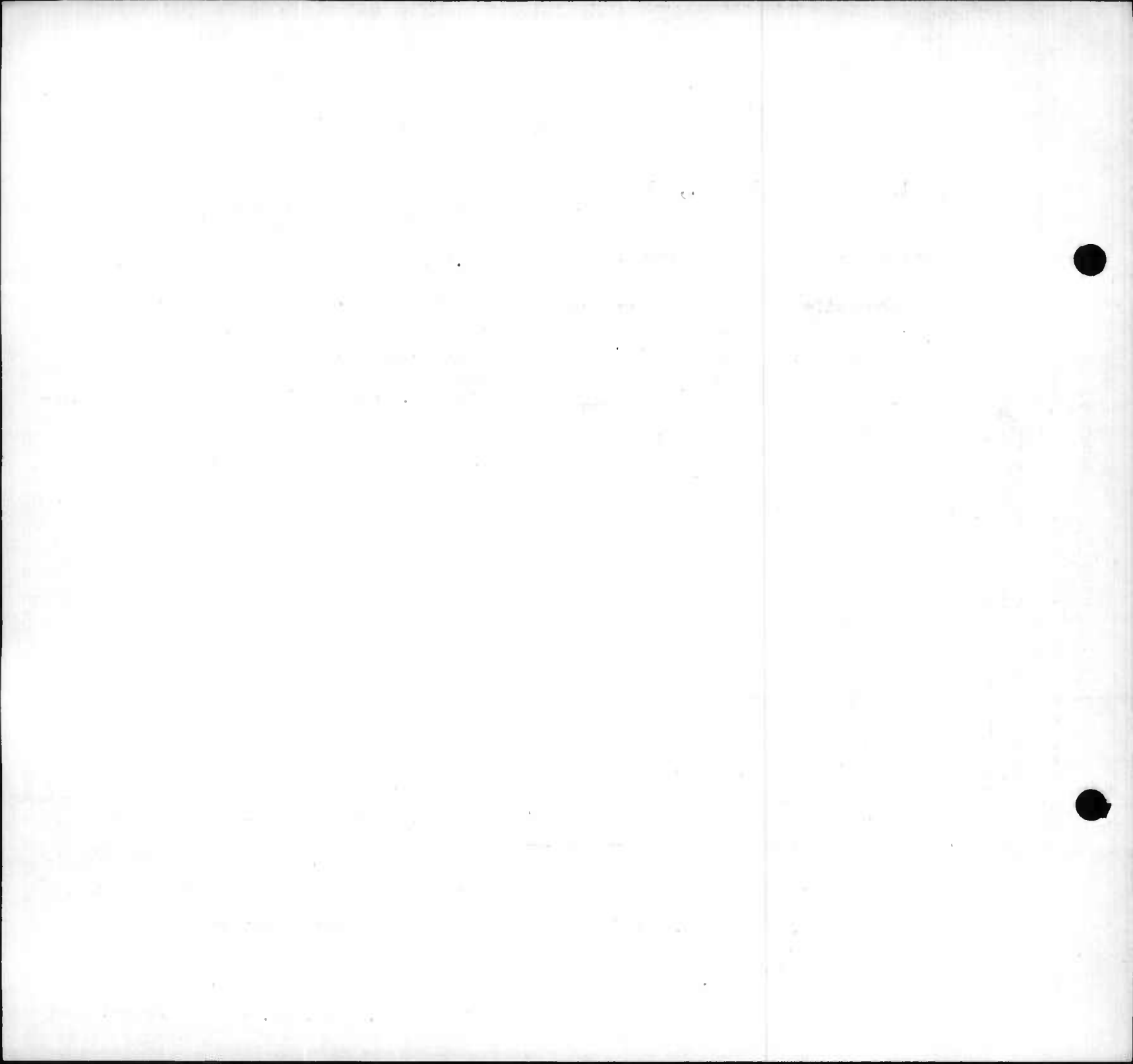


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|--|---|--|--|--|--|--|---|
| 66 04062
CERTIFICATE OF DEATH | | | | | Registered No. 66 04062 | | | | |
| BIRTH NO.
M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) ELLA N. HAND | | | | | 2. DATE AND HOUR OF DEATH
April 18, 1966 8:55 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

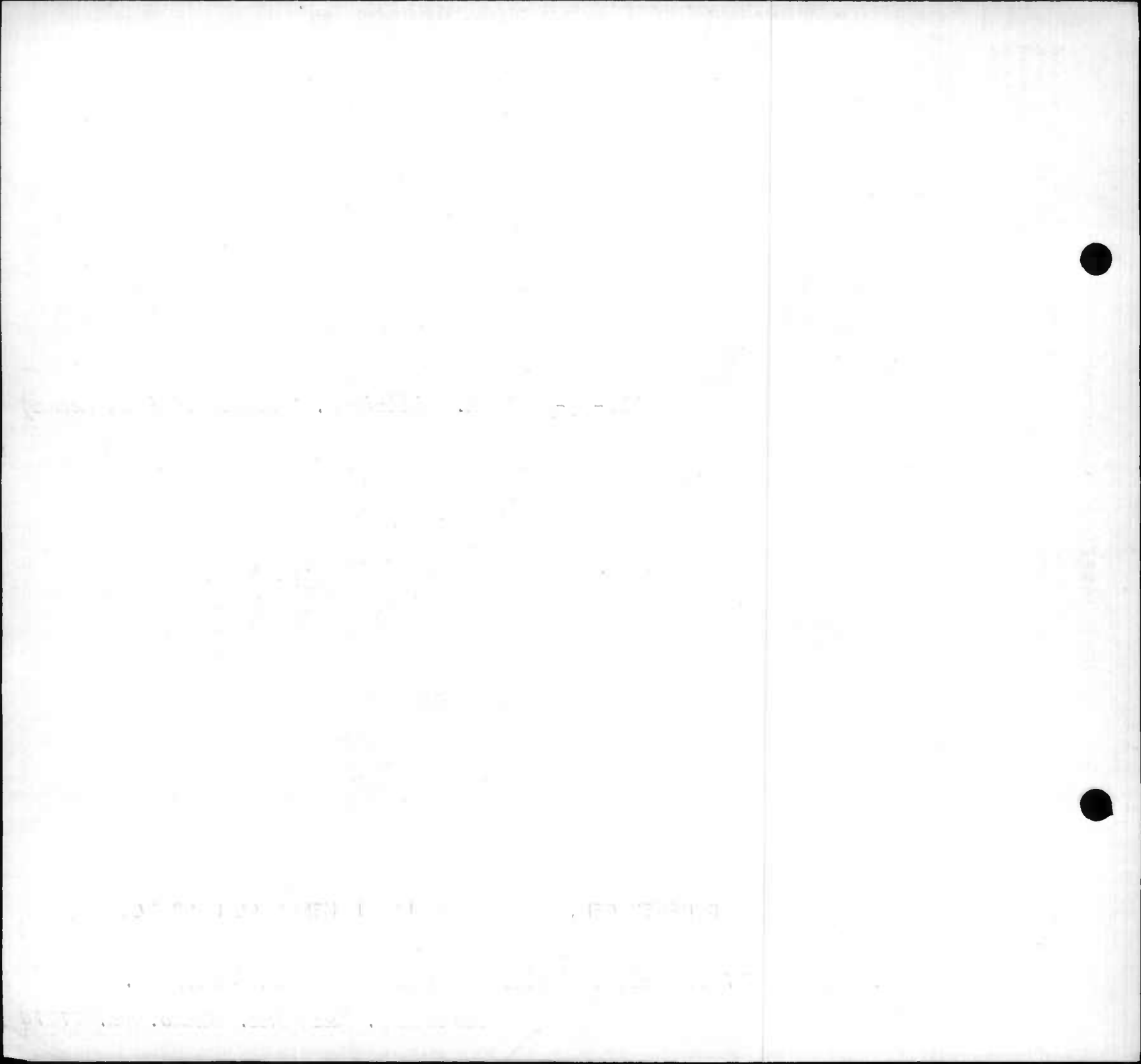
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
917 Chestnut Hill Ave., #18 | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY, none
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
917 Chestnut Hill Avenue, 18 | | | | |
| 5. SEX
female | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
Nov. 28, 1885 | 9. AGE (In years last birthday)
80 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
Charles Steinbach | | | | | 14. MOTHER'S MAIDEN NAME
Mary MacGarry | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Frank B. Hand | | | | ADDRESS
917 Chestnut Hill Avenue-18 |
| 18. 332X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Cerebral Thrombosis
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH
(A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (the hospital) attended the deceased from April 18 1966 to April 18 1966 , that (I) (we) last saw the deceased alive on April 18 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
William H. Fusting | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/19/66 | | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. William H. Fusting | | | | | 23D. ADDRESS
4230 Loch Raven Boulevard | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
burial | | 24B. DATE
4/22/66. | | 24C. NAME OF CEMETERY or CREMATORY
Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 21 1966 | | | 25B. NAME OF REGISTRAR
Robert E. Fustling | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. - 5305 Harford Road | | | | |



FUNERAL DIRECTOR: IMPORTANT

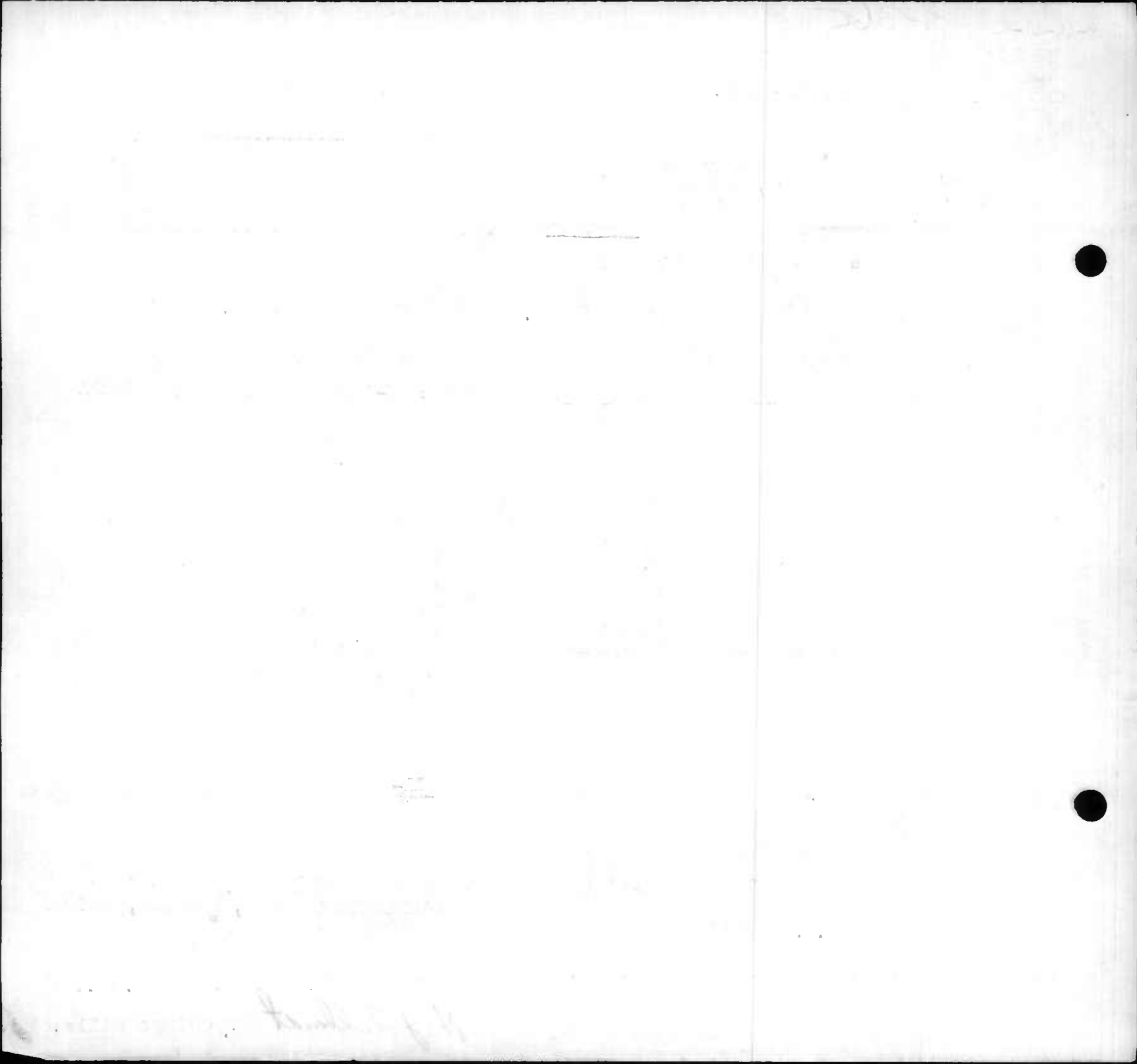
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--------------|--|-----------------------------|---|---|
| 66 04063 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04063 | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | KERSCHENSTEINER, THERESA | | 2. DATE AND HOUR OF DEATH
4/17/66 8:30 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
(MRS. MAX) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
44 UNION MEMORIAL HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 21206 | | | |
| | | D. STREET ADDRESS (If rural, give location)
4604 EUGENE AVE. | | | |
| 5. SEX
F. | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
2/12/86 | 9. AGE (In years last birthday)
80 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Wife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
GERMANY | |
| 12. CITIZEN OF WHAT COUNTRY?
AMERICAN | | 13. FATHER'S NAME
JOHN MERZ BAUER | | 14. MOTHER'S MAIDEN NAME
GERTRUDE LINK | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220-44-5972 | | 17. INFORMANT
Mr. William P. Kerschensteiner (same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
153.1 I
CARCINOMA OF GALL BLADDER 5 WEEKS | | CAUSE OF DEATH
(A) DUE TO
CIRROSIS OF LIVER | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) DUE TO
JAUNDICED | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
34/13/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
INCREASING JAUNDICE | | 20A. AUTOPSY (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 2nd 1966 to April 17th 1966, that (I) (we) lost saw the deceased alive on 4/17 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Godfrey Geh | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/17/66 | |
| 23C. PHYSICIAN'S NAME (Type)
GODFREY GEH | | 23D. ADDRESS
Union Memorial Hospital Baltimore 18 Bop. 60 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/21/66 | | 24C. NAME OF CEMETERY or CREMATORY
Dulaney Valley Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 21 1966 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck Inc. Balto. Md. 21214 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------------|--|-------------------------|--|--------------------------------|---|---------------------------------|
| BIRTH NO. 5-365 | | 66 04064 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04064 | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) MORGAN E. STORMS | | | | 4-18-66 8:05 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
4940 Eastern Avenue
Baltimore, Maryland 21224
BALTO City Hosp | | | | A. STATE Md - B. COUNTY BALTO | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTO | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
1718 St. Paul Street 21202 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Divorced | 8. DATE OF BIRTH 5-6-05 | 9. AGE (In years last birthday) 60 | 10. If Under 1 Yr. Months Days | | 11. If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Conductor | | 10B. KIND OF BUSINESS OR INDUSTRY
TRANSIT CO. | | 11. BIRTHPLACE (State or foreign country)
Baltimore County, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
HENRY Levi Storms | | | | 14. MOTHER'S MAIDEN NAME
MARY Louise Bartell | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No -- | | 16. SOCIAL SECURITY NO.
213-1072664 | | 17. INFORMANT ADDRESS
Records: BCH-4940 Eastern Avenue 21224
CHART | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
422.11260X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
ANTecedent CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) DUE TO Congestive Ht. failure 1 mo. -
AS CVD
(B) DUE TO 5 yr.
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Chr Renal Dis, Obesity, Diabetes Mellitus | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 4-18-66 to 4-18-66, that (1) (we) last saw the deceased alive on 4-18-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE J. E. Randall | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 4-18-66 | |
| 23C. PHYSICIAN'S NAME (Type) J.E. Randall | | | | 23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland
BALTO City Hosp | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4/21/66 | | 24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery | | 24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 21 1966 | | 25B. NAME OF REGISTRAR R. E. Fink | | 25C. FUNERAL DIRECTOR H. J. Eckhardt | | ADDRESS Owings Mills, Md. | |



BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED
(Type or Print)

WILLIAM E. PRUITT

2. DATE AND HOUR PRONOUNCED DEAD

April 17, 1966 9:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Owings Mills

D. STREET ADDRESS (If rural, give location)

10418 Reisterstown Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never Married

8. DATE OF BIRTH

March 7, 1937

9. AGE (In years
last birthday)

29

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Teletype Operator

10B. KIND OF BUSINESS OR INDUSTRY

Md. State Police

11. BIRTHPLACE (State or foreign country)

Abingdon, Virginia

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Robert Lee Pruitt

14. MOTHER'S MAIDEN NAME

Lillian B. Phillips

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

National Guard 1955-62

16. SOCIAL
SECURITY NO.

213-36-7759

17. INFORMANT

Robert L. Pruitt

ADDRESS

10418 Reistersto
Owings Mills, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/17/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/20/66

23C. NAME OF CEMETERY or CREMATORY

Evergreen Mem. Gardens

23D. LOCATION

(City, town, or county)

(State)

Finksburg, Maryland

24A. DATE REC'D BY HEALTH DEPT.

APR 21 1966

24B. NAME OF REGISTRAR

A. J. E. Farley, M.D.

24C. FUNERAL DIRECTOR

A. J. E. Farley, M.D.

ADDRESS

Owings Mills, Md.

WALTER LONG

March 7, 1957
Honorable Earl Warren
U.S. Supreme Court Building
Washington, D.C.

Dear Mr. Chief Justice:
I am writing to you today to express my deep concern over the recent developments in the civil rights movement. The actions of the federal government, particularly the Supreme Court, have been a source of great disappointment and frustration to many of our people.

Sincerely,
Walter Long

Walter Long

483 M 11

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|--------------------------------------|--|-----------------------------|
| BIRTH NO.
66 04066 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 66 04066 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print)
PHILIP CAPLAN | | 2. DATE AND HOUR OF DEATH
4-19-66 7:10 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION
SINAI HOSPITAL
(If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 6938 BROOKMILL RD. APT #15 | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. <input checked="" type="checkbox"/> MARRIED; NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
4-19-1907 | 9. AGE (In years, Months, Days)
57 | 10. Under 1 Yr. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
ROUTE SUPERVISOR | | 10B. KIND OF BUSINESS OR INDUSTRY
SUN PAPERS | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MD. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
LOUIS CAPLAN | | 14. MOTHER'S MAIDEN NAME
ROSE ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MRS. RUTH CAPLAN 6938 BROOKMILL RD APT 1C | |
| 18. 260X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Renal failure
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DUE TO
Renal failure
(B) DUE TO
Kimmelstiel-Wilson Disease
(C) DUE TO
Diabetes Mellitus | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>April 16, 1966</u> to <u>April 19, 1966</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>April 19, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Gerardo M. Ypil Jr. | | M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/19/66 | |
| 23C. PHYSICIAN'S NAME (Type)
GERARDO M. YPIL JR. | | 23D. ADDRESS
SINAI HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/20/66 | | 24C. NAME OF CEMETERY or CREMATORY
HEBREW YOUNG MEN | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT.
APR 21 1966 | | | |
| 25B. NAME OF REGISTRAR
R. E. F. J. J. | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | |

2101 HOSPITAL



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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. | |
|---|-----------|--|-----------------------------------|--|---|------------------|--|----------------------------------|--|----------------|--|
| BIRTH NO. | | 66 04067 | | | | | | | | 66 04067 | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | | | |
| RIBACK HARRY | | | | | April 19, 1966 11:40 a.m. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | | | MARYLAND | | | | | | |
| LEVINDALE, HEBREW HOME AND INFIRMARY | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
1721 EAST BALTIMORE STREET | | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | | | If Under 24 Hrs. Hours Min. | | | |
| MALE | WHITE | WIDOWED | | 88 | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| MERCHANT | | | RETAIL | | POLAND | | | USA | | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | |
| UNKNOWN ISAAC RIBACK | | | | | UNKNOWN SARAH ? | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| NO | | | 212-24-9011 | | MRS. MINNIE MORDES 3635 GLENGYLE AVE APT C5 | | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) DUE TO | | | Pneumonia, massive 2 days | | | |
| ANTECEDENT CAUSES | | | | | (B) DUE TO | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (C) DUE TO | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | ASCVD chronic pulmon. disease | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 0 | | | | | No | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from March 21 1966 to April 19 1966, that (1) (we) last saw the deceased alive on April 19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | | 4.19.66 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | M.D. | | | | | | | |
| RUTH WILLNER | | LEVINDALE, HEBREW HOME AND INFIRMARY | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | | | | | |
| BURIAL | 4/20/66 | RUDOMER VEREIN | | ROSEDALE, MARYLAND | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | | | | | | | |
| APR 21 1966 | | Robert E. Johnson | | SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|--|--|--|--|---|--|---|--|
| N-1621
66 04068
CERTIFICATE OF DEATH | | | | | Registered No. 66 04068 | | | | |
| 1. NAME OF DECEASED
(Type or Print)
LOUIS J. NEUBURGER | | | | | 2. DATE AND HOUR OF DEATH
APRIL 19, 1966 10:10 A M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
SINAI HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
6107 ROBIN HILL ROAD | | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
8/20/1925 | 9. AGE (In years last birthday)
40 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MANAGER | | 10B. KIND OF BUSINESS OR INDUSTRY
CATERING COMPANY | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
JACOB NEUBURGER | | | | | 14. MOTHER'S MAIDEN NAME
REBECCA ASCHER | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES WW 2 ARMY | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
MRS. MARILYN NEUBURGER 6107 ROBIN HILL ROAD | | | | |
| 18. 4-20-1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ACUTE CORONARY OCCLUSION - 1/2 hr
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-15 19 64 to 4/19 19 66 , that (I) (we) last saw the deceased alive on 4/16 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Norman R. Kleiman M.D. | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED
APRIL 19, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. NORMAN KLEIMAN | | | 23D. ADDRESS
3803 EDMONDSON AVENUE | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY
HEBREW FRIENDSHIP | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 21 1966 | | 25B. NAME OF REGISTRAR
Robert E. Seligman | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC. | | | ADDRESS
8010 REISTERSTOWN ROAD | | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 04069BIRTH NO. 65 04069

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)(LILLIAN)
DORIS L. GLICKMAN

2. DATE AND HOUR PRONOUNCED DEAD

April 18, 1966

3:25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

909 W. University Parkway

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

909 W. University Pkwy. Apt. 12A

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
NEVER MARRIED

8. DATE OF BIRTH

8/18/1912

9. AGE (In years
last birth)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

DEPT OF MOTOR VEHICLES

10B. KIND OF BUSINESS OR INDUSTRY

STATE OF MD

11. BIRTHPLACE (State or foreign country)

BOSTON, MASS.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

DAVID H. GLICKMAN

14. MOTHER'S MAIDEN NAME

RAE L. GREENE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MR. MILTON D. GLICKMAN 2712 GEARTNER ROAD

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) EXCESS

Hypertensive cardiovascular disease

with apoplectic hemorrhage in cerebellum

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) DUE TO(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

219B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT ☐
m. WORKNOT WHILE ☐
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

4-19-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

REMOVAL & BURIAL 4/20/66

23B. DATE

23C. NAME of CEMETERY or CREMATORY

TEMPLE MISHKEN TEFILA

23D. LOCATION

(City, town, or county)

(State)

DEADHAM, MASSACHUSETTS

24A. DATE REC'D BY HEALTH DEPT.

APR 21 1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

6070 REISTERSTOWN ROAD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | |
|--|--|---------------|--|--|---|-----------------------------|--|--|--|---|--|--|--|--|--|
| BIRTH NO. | | | | | CERTIFICATE OF DEATH | | | | | Registered No. | | | | | |
| M.E. CASE NO. 66 04070 | | | | | 1. NAME OF DECEASED (Type or Print) ISAAC SIEGEL | | | | | 2. DATE AND HOUR OF DEATH 4/19/66 1 55 P M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | A. STATE B. COUNTY | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | MARYLAND | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | |
| BELVEDERE NURSING HOME
2525 W BELVEDERE AVE | | | | | BALTIMORE | | | | | D. STREET ADDRESS (If rural, give location)
4118 WEST ROGERS AVENUE | | | | | |
| 5. SEX MALE | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH 12/20/1884 | | 9. AGE (In years last birthday) 87 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | | | 10B. KIND OF BUSINESS OR INDUSTRY MERCHANT | | | | 11. BIRTHPLACE (State or foreign country) RUSSIA | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME UNKNOWN | | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | | 16. SOCIAL SECURITY NO. 218-32-4069 | | | | | 17. INFORMANT ADDRESS MR. SYLVAN SIEGEL 2105 WEST PRATT STREET | | | | | |
| 18. CAUSE OF DEATH | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | (A) DUE TO Carcinoma Sigmoid Colon 2 yrs | | | | | |
| 18B. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | (B) DUE TO Atherosclerotic C.V. Disease | | | | | |
| 18C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | (C) DUE TO | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) NO | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1942 to 4/19 1966, that (I) (we) last saw the deceased alive on 4/18 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 23A. SIGNATURE Edward A. Kallins M.D. | | | | | | | | | | 23B. DATE SIGNED 4/19/66 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) EDWARD A. KALLINS | | | | | | | | | | 23D. ADDRESS 4300 Liberty Hts Dr Baltimore 7 Md | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | 24B. DATE 4/20/66 | | | | 24C. NAME OF CEMETERY or CREMATORY BNAI ISRAEL | | | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 21 1966 | | | | 25B. NAME OF REGISTRAR Robert E. J. J. J. | | | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | | ADDRESS | | | |



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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|---|--|-------------------------|--|--|--|------------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| BIRTH NO. 66 04071 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 04071 | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) STERN, ABRAHAM | | | | | 2. DATE AND HOUR OF DEATH
4/18/66 1:05 P.M. | | | | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
42 SINAI HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4013 ROSECREST AVE | | | | | | | | | | | | | | |
| 5. SEX
Male | | 6. RACE
White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
8/22/95 | | 9. AGE (In years last birthday)
70 | | 10. If Under 1 Tr. Months: Days: Hours: Min. | | 11. If Under 24 Hrs. Months: Days: Hours: Min. | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
BOOKKEEPER | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
HANOVER SHIRT COMPANY | | | | | 11. BIRTHPLACE (State or foreign country)
KANSAS CITY, MISSOURI | | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME
ISAAC JACOB STERN | | | | | 14. MOTHER'S MAIDEN NAME
LEAH ROSE | | | | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | | 16. SOCIAL SECURITY NO.
XXXXXXXXXXXX | | 17. INFORMANT
MRS. NAMIE STERN | | | | | ADDRESS
4013 ROSECREST AVENUE | | | | | | | |
| 18. 42011 | | | | | CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) DUE TO
Acute Myocardial Infarct - 3 months | | | | | | | | | | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) DUE TO
Arteriosclerotic Cardiovascular Disease | | | | | | | | | | | | | | |
| | | | | | (C) Coronary Heart failure 1 week | | | | | | | | | | | | | | |
| II | | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Heart's Disease | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION
None | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
None | | | | | 20A. AUTOPSY? (Yes or No)
No | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)
NONE | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
— | | | | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
— | | | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
— | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR?
— | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 14 19 66 to April 15 19 66 , that (I) (we) last saw the deceased alive on April 18 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE
George Banks | | | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED
4/18/66 | | | | |
| 23C. PHYSICIAN'S NAME (Type)
GEORGE BANKS | | | | | | | | | | M.D. 23D. ADDRESS
SINAI HOSPITAL Baltimore 21215 | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | | | 24B. DATE
4/19/66 | | | | | 24C. NAME OF CEMETERY or CREMATORY
BOBROISKER BENEFICIAL CIRCLE | | | | | 24D. LOCATION (City, town, or county) (State)
ROSEDALE, MARYLAND | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 21 1966 | | | | | 25B. NAME OF REGISTRAR
Robert E. Fisher | | | | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC. | | | | | ADDRESS
6010 REISTERSTOWN RD | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04072 | |
|---|------------------|--|-----------------------------|--|---|
| BIRTH NO.
M.E. CASE NO. | | 66 04072 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) SPEVAK, SHIRLEY (SNYDER) | | 2. DATE AND HOUR OF DEATH
4/20/66 5:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
SINAI HOSPITAL OF BALTO. INC. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
MARYLAND - BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
3117 BONNIE ROAD | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
1/20/28 | 9. AGE (In years last birthday)
38 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
AT HOME | | 11. BIRTHPLACE (State or foreign country)
NEW YORK | |
| 13. FATHER'S NAME
HYMAN I. SNYDER | | 14. MOTHER'S MAIDEN NAME
SARA RUDOLPH | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MR. FRANK SPEVAK 3117 BONNIE ROAD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)
350X I
SUBARACHNOID HEMORRHAGE
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH
(A) DUE TO
SUBARACHNOID HEMORRHAGE
(B) DUE TO
HYPERTENSION (10 years)
(C) DUE TO
ANEURYSM | | INTERVAL BETWEEN ONSET AND DEATH
3 days | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/18 1966 to 4/20 1966, that (I) (we) last saw the deceased alive on 4/20 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
A. G. CORMAN | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/20/66 | |
| 23C. PHYSICIAN'S NAME (Type)
A. G. CORMAN | | 23D. ADDRESS
SINAI HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/21/66 | | 24C. NAME OF CEMETERY or CREMATORY
MOSES MONTIFILORE WOODMOOR HEBREW | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT.
APR 21 1966 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | |

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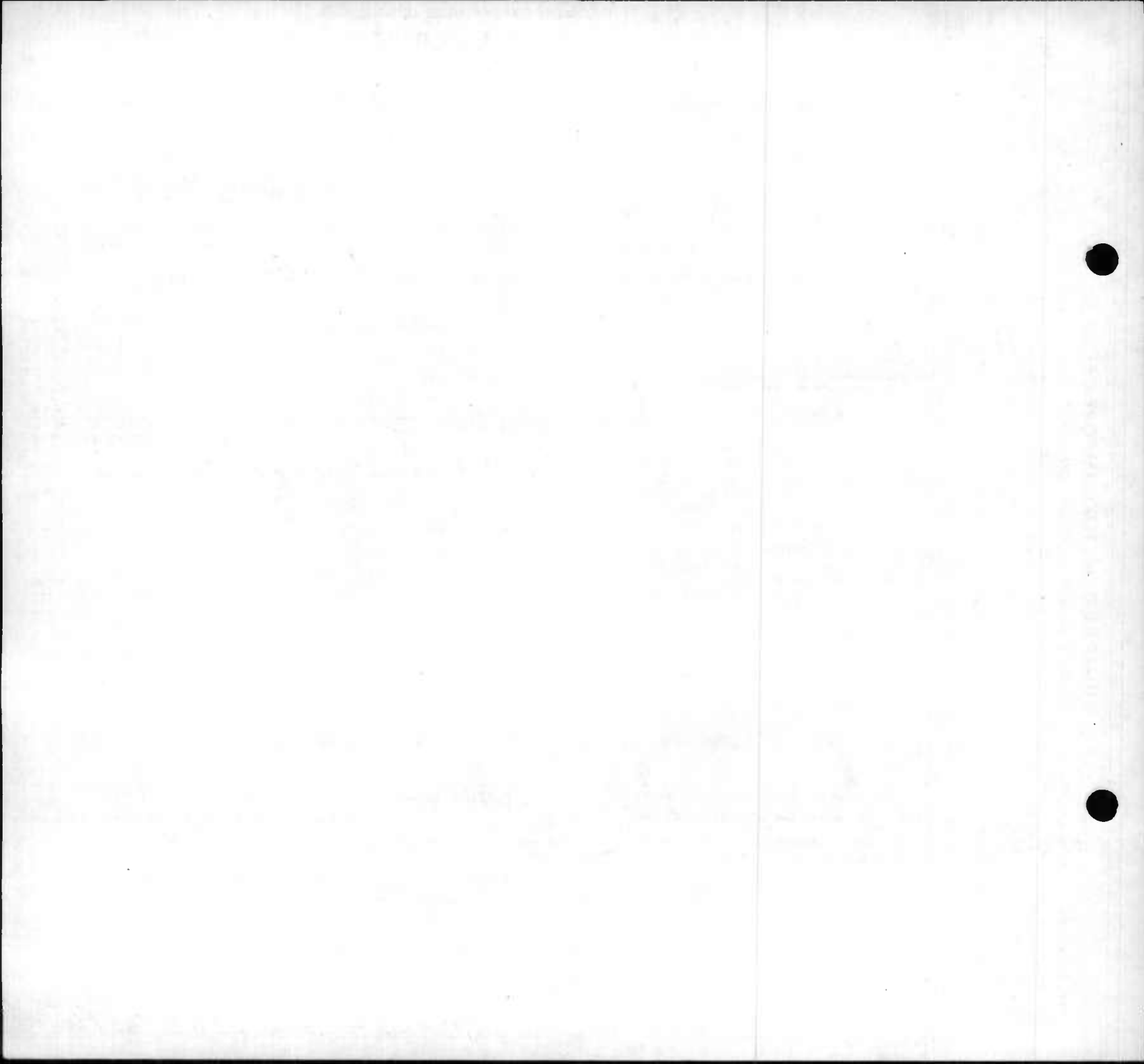
1963

1964

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

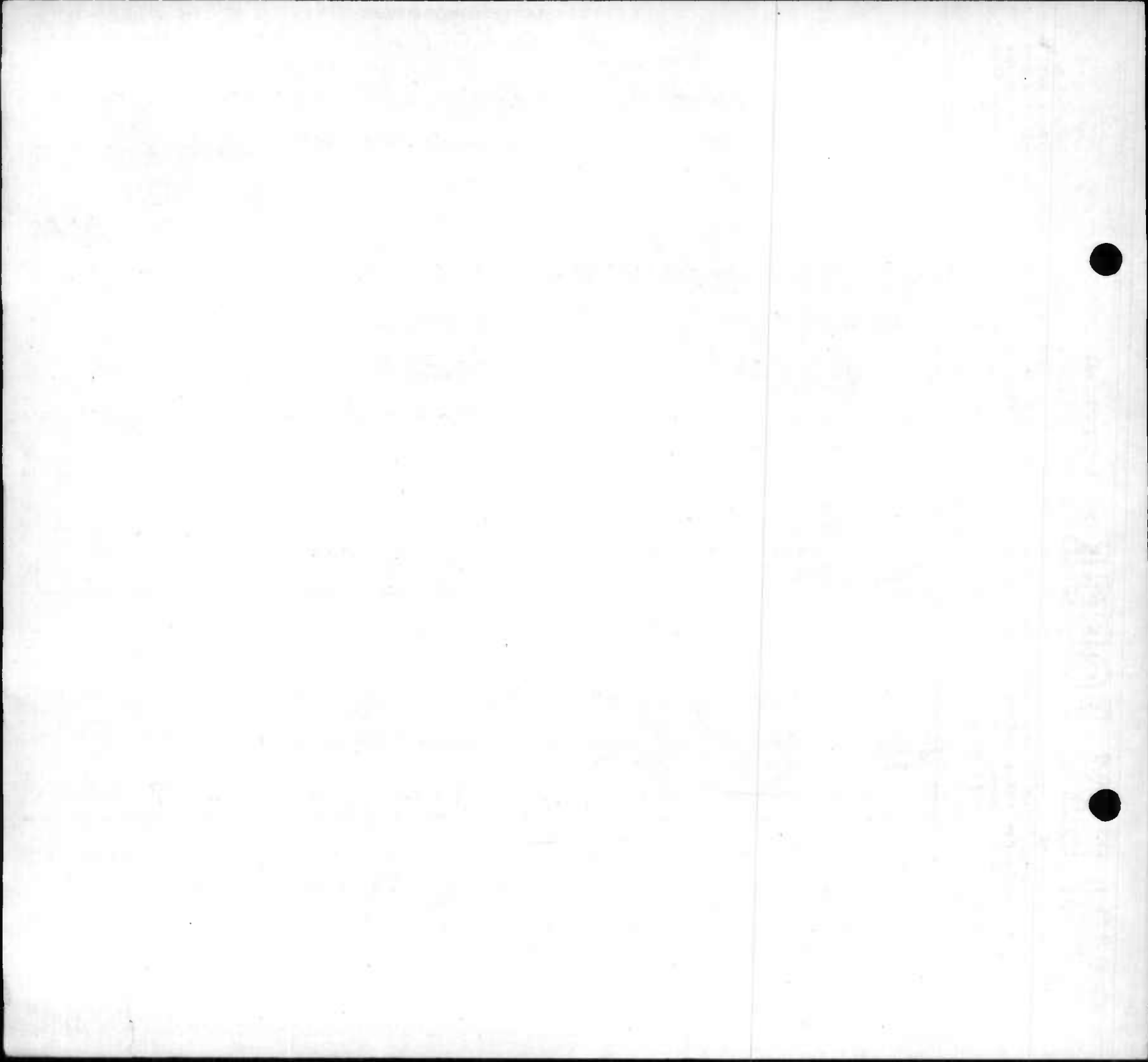
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|--|--|--|--|--|
| 66 04073 | | CERTIFICATE OF DEATH | | 66 04073 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | | |
| | | Kotowski, Andrew | | | |
| 2. DATE AND HOUR OF DEATH | | 4/17/66 11:10 PM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE
B. COUNTY | | | |
| North Charles General Hospital
2724 N. Charles Street. | | 815 N. Chester St.
Baltimore, Maryland | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | |
| M | | Polish W | | | |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. CITIZEN OF WHAT COUNTRY? | |
| 3-31-99 | | 72 | | U.S.A. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Long shore man | | Retired | | Poland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| James Kotowski | | Marie Mycoski | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Yes | | WWI | | MR. JOHN KOTOWSKI 816 BROADVIEW BLVD. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 5-02-01 | | Bronchitis - Emphysema | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) DUE TO | | | |
| | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/19/66 19 to 4/17/66 19 that (I) (we) last saw the deceased alive on 4/17/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| [Signature] | | | | 4/17/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| BURIAL | | 4-20-1966 | | BALTIMORE NATIONAL CEM | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| APR 21 1966 | | R. E. E. F. J. J. J. | | RAYMOND L. KACZOROWSKI 2525 FLEETS. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|--------------------------------------|--|---|
| BIRTH NO.
66 04074 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 66 04074 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) MARY FLORENCE HIMMELMAN | | 2. DATE AND HOUR OF DEATH
4/17/66 2:25 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 26-11 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
816 S. CLINTON ST. | | D. STREET ADDRESS (If rural, give location)
816 S. CLINTON ST. | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
3-11-1890 | 9. AGE (In years last birthday)
76 YRS. | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
JOHN HENNIGAN | | 14. MOTHER'S MAIDEN NAME
ELIZABETH DUNNIGAN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
MR. EARL HIMMELMAN 7102 GOUCH ST. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
350X1
CAUSE OF DEATH
Viral pneumonia
(A) DUE TO
Parkinson's Disease
(B) DUE TO
Hypertension
(C) | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (the hospital) attended the deceased from 4/16 2:22 19 66 to 4/17 19 66 , that (I) (we) last saw the deceased alive on 4/16 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
E. A. FLANIGAN JR.
M.D.
Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | |
| 23B. DATE SIGNED
4/18/66 | | 23C. PHYSICIAN'S NAME (Type)
E. A. FLANIGAN JR.
M.D. | | 23D. ADDRESS
3501 Fairview Baltimore, MD 21214 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4-20-1966 | | 24C. NAME OF CEMETERY OR CREMATORY
OAKLAWN CEMETERY | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT.
APR 21 1966 | | 25B. NAME OF REGISTRAR
Robert E. [unclear] | |
| 25C. FUNERAL DIRECTOR
HOFFMANN FUNERAL HOME | | 25D. ADDRESS
3218 HUDSON ST. | | | |

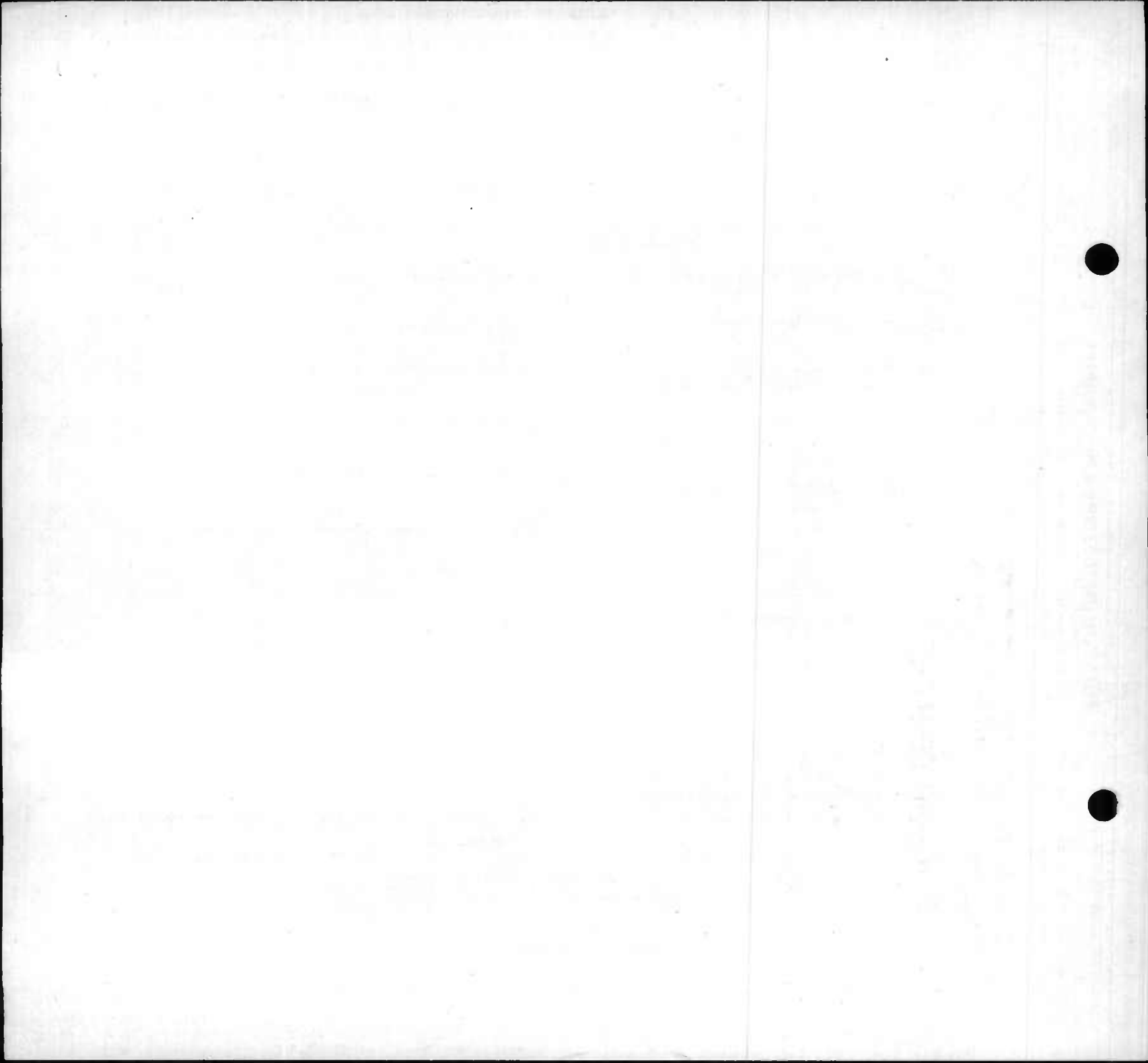


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|---|--|-------------------------|--|--|---|--|--|--|--|--|--|-----------------------|--|--|---|--|--|--|--|
| BIRTH NO. 66 04075 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 04075 | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print)
John F. W. Becker | | | | | 2. DATE AND HOUR OF DEATH
April 15, 1966 1 12⁰⁵ P.M. | | | | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Maryland General Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
Baltimore, Maryland
B. COUNTY
FOI
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
FOI
D. STREET ADDRESS (If rural, give location)
1107 S. Ellwood Ave. | | | | | | | | | | | | | | |
| 5. SEX
Male | | 6. RACE
Cauc. | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
Mar. 19, 1890 | | 9. AGE (In years last birthday)
76 | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) | | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | | |
| 13. FATHER'S NAME
George Becker | | | | | 14. MOTHER'S MAIDEN NAME
Margaret Biemuller | | | | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT
Chart | | | | | ADDRESS | | | | |
| 18. 157X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
GASTRIC CARCINOMA
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | CAUSE OF DEATH
(A) DUE TO
GI Bleed
(B) DUE TO
GI Bleed
(C) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH
> 2 days | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No)
Yes | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 12, 1966 to April 15, 1966 , that (I) (we) last saw the deceased alive on 4/15, 1966 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE
Ronald T. Lewers | | | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED
4/15/66 | | | | |
| 23C. PHYSICIAN'S NAME (Type)
Donald T. Lewers | | | | | | | | | | 23D. ADDRESS
Md Gen Hosp. | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | | | 24B. DATE
4-19-1966 | | | | | 24C. NAME OF CEMETERY or CREMATORY
OAK LAWN CEMETERY | | | | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE MD. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 21 1966 | | | | | 25B. NAME OF REGISTRAR
Robert E. [illegible] | | | | | 25C. FUNERAL DIRECTOR
HOFFMANN FUNERAL HOME | | | | | ADDRESS
3218 HUDSON ST. | | | | |

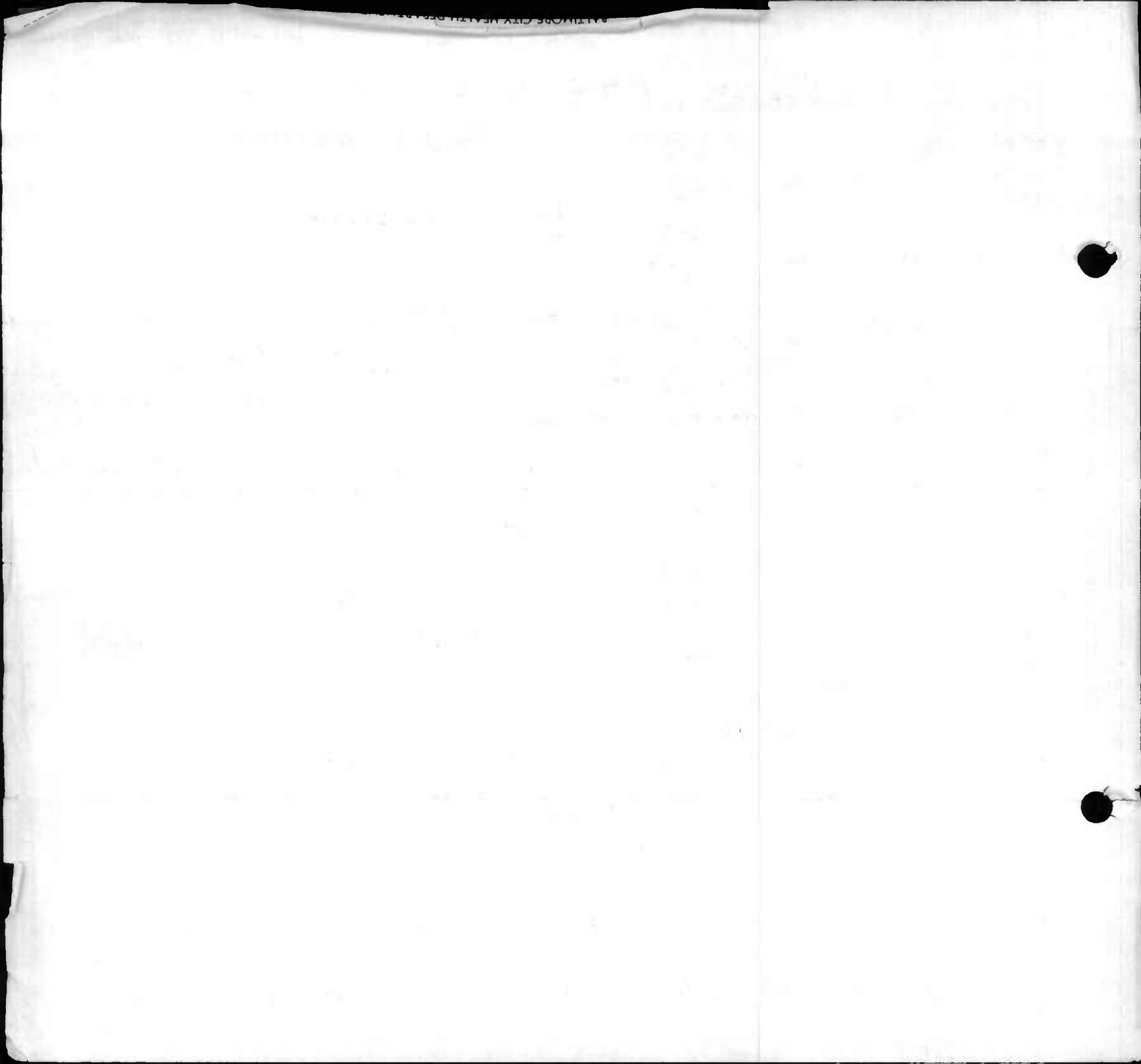


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|--|---|---|
| BIRTH NO. 66 04076 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04076 | |
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) WALTERS, MARIE MABEL | | | 2. DATE AND HOUR OF DEATH
April 17, 1966 8 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
SINAI HOSP | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 3322 Shelburne Rd | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 10/1/88 | 9. AGE (In years last birthday) 76 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired H-W | | 10B. KIND OF BUSINESS OR INDUSTRY own home | 11. BIRTHPLACE (State or foreign country) BALTO | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Frank P. Ward | | | 14. MOTHER'S MAIDEN NAME Mary Toenies | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | 17. INFORMANT ADDRESS HARRY M. WALLEN M.D. SINAI HOSP | | |
| 18. 443X1-260X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
possible Cerebral Vascular accident
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Immediate | | | INTERVAL BETWEEN ONSET AND DEATH
5 years | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus 5 years | | | | | |
| 19A. DATE OF OPERATION none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) none | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 4-16-66 19 to 4-17-66 19, that (1) (we) last saw the deceased alive on 4-17-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE HARRY M. WALLEN M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 4-17-66 | |
| 23C. PHYSICIAN'S NAME (Type) HARRY M. WALLEN | | 23D. ADDRESS SINAI HOSP OF BALTO | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE April 20, 1966 | | 24C. NAME OF CEMETERY OR CREMATORY Daniel High Lane Park, Baltimore, Md. | |
| 24D. LOCATION (City, town or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. APR 21 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR Frank H. Newell | | | |



BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

FREDERICK G. BOWEN

2. DATE AND HOUR PRONOUNCED DEAD

April 18, 1966 10:31 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

CHURCH HOME AND HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

329 S. Gilmore Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Single

8. DATE OF BIRTH

4-16-1948

9. AGE (In years
last birthday)

18

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Frederick A. Bowen

14. MOTHER'S MAIDEN NAME

McConville

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

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16. SOCIAL
SECURITY NO.

213 52 2799

17. INFORMANT

ADDRESS

Mrs. Florence Bowen, 329 S. Gilmore Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Craniocerebral injury and comminuted
DUE TO fracture of jaw with aspiration
of blood

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Caroline and Gough Streets

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
4 18 66 7:30 P.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Passenger in motorcycle-truck collision

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-19-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4-22-1966

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 21 1966

Robert E. Fisher, M.D.

Thomas J. Kenny, Inc., 1600 Hollins St. Balto.



AC 100-100



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | |
|--|--|--------------------|--|--|--|-----------------------------------|--|--|--|---|--|---------------------------------|--|--|---|--|
| BIRTH NO. 66 04078 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 04078 | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>John A. Wagner</u> | | | | | 2. DATE AND HOUR OF DEATH
<u>April 17 1966</u> <u>1:50</u> P.M. | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (When deceased lived. If institution: residence before admission) | | | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Maryland General Hosp</u>
<u>Balto md.</u> | | | | | A. STATE <u>MD</u>
B. COUNTY <u>27-12</u> | | | | | | | | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Balto</u> <u>21212</u> | | | | | D. STREET ADDRESS (If rural, give location)
<u>406 Cedarcroft Rd.</u> | | | | | | | | | | | |
| 5. SEX <u>M</u> | | 6. RACE <u>Can</u> | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Widowed</u> | | 8. DATE OF BIRTH
<u>4/6/91</u> | | 9. AGE (In years
last birthday) <u>05</u> | | If Under 1 Yr.
Months: Days | | If Under 24 Hrs.
Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)
<u>Retired</u> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Business Exec.</u> | | | | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | | | | 12. CITIZEN OF
WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>John Wagner</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Katherine Lentz</u> | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | | | 16. SOCIAL SECURITY NO.
<u>216-18-3654</u> | | | | | 17. INFORMANT
<u>Daughter Charlotte M. Wagner</u> | | | | | ADDRESS | |
| 18. <u>422.11</u>
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)
<u>Bronchopneumonia</u> | | | | | CAUSE OF DEATH
(A) DUE TO
<u>Pulmonary edema</u> | | | | | INTERVAL BETWEEN
ONSET AND DEATH
<u>several days</u> | | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.
<u>arteriosclerosis of C.A. Ar.</u> | | | | | (B) DUE TO | | | | | (C) <u>many years</u> | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | | | | 19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) | | | | | 21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While
At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that <u>HT</u> (this hospital) attended the deceased from <u>4/14</u> 19 <u>66</u> to <u>4/17</u> 19 <u>66</u> ,
that <u>HT</u> (we) last saw the deceased alive on <u>4/17</u> 19 <u>66</u> and that in (my) <u>last</u> opinion death occurred on the date
and hour and from the causes stated above. (I) <u>Wet</u> (did) <u>(did not)</u> view the body after death. | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE
<u>Donald T. Lewers</u> | | | | | M.D. <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED
<u>4/17/66</u> | | | | | | |
| 23C. PHYSICIAN'S
NAME (Type)
<u>Donald T. Lewers</u> | | | | | M.D. <u>MD</u> | | | | | 23D. ADDRESS
<u>Maryland General Hospital</u> | | | | | | |
| 24A. BURIAL CREMATION,
REMOVAL (Specify)
<u>Burial</u> | | | | | 24B. DATE
<u>4/21/66</u> | | | | | 24C. NAME OF CEMETERY or CREMATORY
<u>Landon Pk</u> | | | | | 24D. LOCATION (City, town or county) (State)
<u>Balto. 29. Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 21 1966</u> | | | | | 25B. NAME OF REGISTRAR
<u>Robert E. Lewis</u> | | | | | 25C. FUNERAL DIRECTOR
<u>Witzke F. D. 4101 Edmondson</u> | | | | | ADDRESS | |

Handwritten text, likely bleed-through from the reverse side of the page. The text is faint and illegible.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|--|--|--|
| BIRTH NO. 66 04079 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04079 | |
| M.E. CASE NO. 66 04079 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Eliza Arthur (Liza J. Arthur) | | | 2. DATE AND HOUR OF DEATH
April 19, 1966 7:15 PM. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital
1514 Division Street
Baltimore, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 14-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2116 Druid Hill Avenue | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
2-14-1906 | 9. AGE (In years last birthday)
60 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10B. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Unknown | | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Jessie (son) 26 N. Carrollton Ave. |
| 18. 444X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Acute Pulmonary Edema -
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Hypertensive Disease | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO
INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 19, 1966 to April 19, 1966 , that (I) (we) last saw the deceased alive on April 19, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
R. Theodore
M.D.
Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
April 20, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
Roger Theodore | | | | 23D. ADDRESS
M.D. 1514 Division Street | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/23/66 | | 24C. NAME OF CEMETERY OR CREMATORY
Bishop. | |
| 24D. LOCATION
Bishopville S. C. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 21 1966 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Parker | | 25C. FUNERAL DIRECTOR ADDRESS
Charles A. Rice 661 W. Barr | | | |

Maryland
Baltimore
2100 North Hill Avenue

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2-14-1914

Female Negro

Maryland

None

None

Unknown

Unknown

Female (non) 25 N. Baltimore

April 19, 1914

April 19, 1914

April 19, 1914

X

1914 Division Street

1914 Division Street

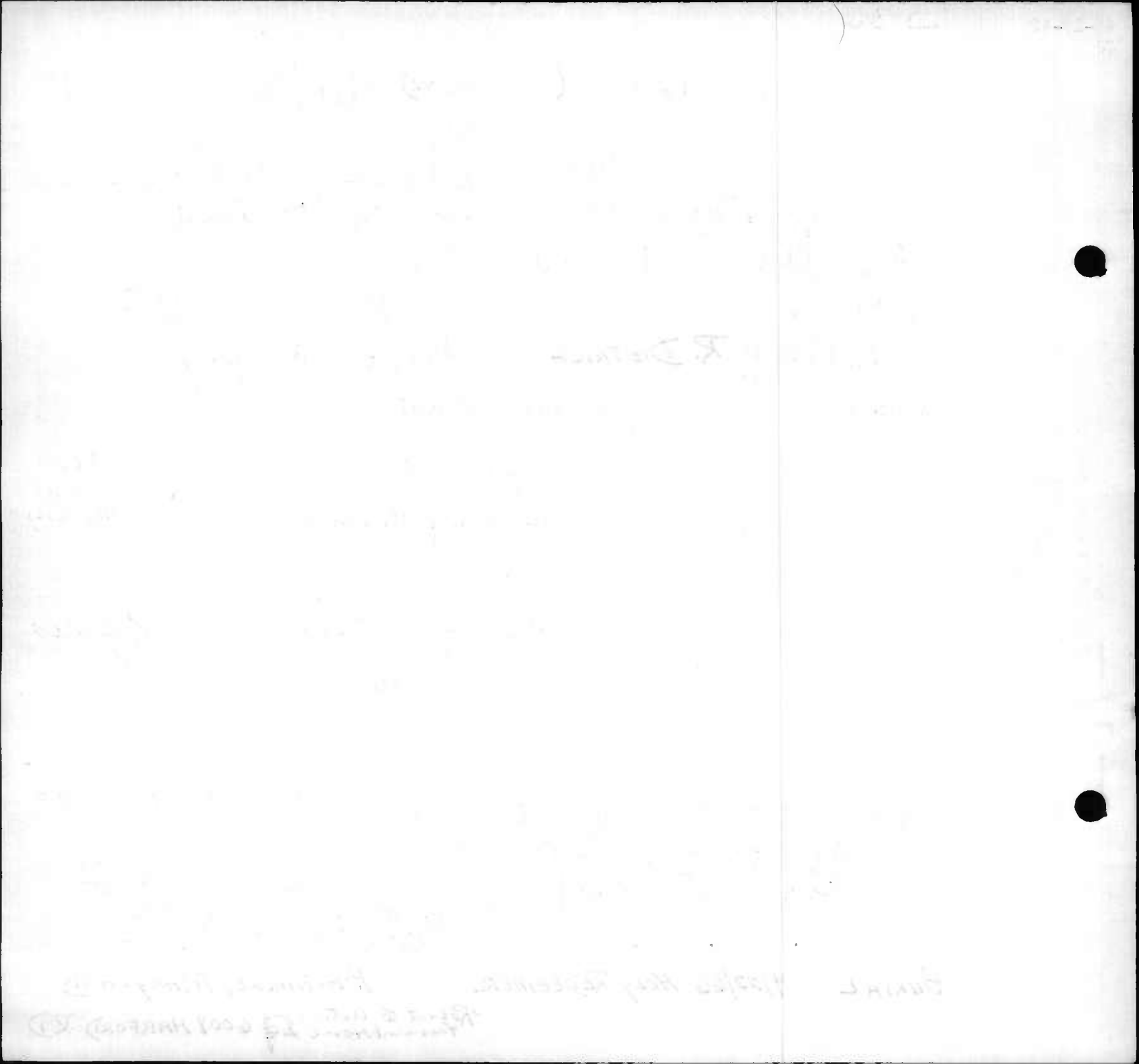
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

Registered No.

66 04080

| | | | | | |
|--|--------------|---|-----------------------------|--|---|
| BIRTH NO. 88 04080 | | CERTIFICATE OF DEATH | | Registered No. 04080 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Fred Dietrich (FREDERICK W.) | | 2. DATE AND HOUR OF DEATH
4/18/66 10 ¹⁰ P M | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Baltimore City Hospitals
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224 | | A. STATE Md
B. COUNTY Balt | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 21234 53-00 | |
| | | D. STREET ADDRESS (If rural, give location)
2608 Wycliffe Road | | | |
| 5. SEX M | 6. RACE Cauc | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Divorced | 8. DATE OF BIRTH
7-26-03 | 9. AGE (In years, lost birthday)
62 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
unknown | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Md | |
| 12. CITIZEN OF WHAT COUNTRY?
US | | 13. FATHER'S NAME
Richard R. Dietrich | | 14. MOTHER'S MAIDEN NAME
Mary E. Murphy | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Unknown | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
chart | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (A) DUE TO pneumonia
(B) DUE TO L hemiparesis
(C) DUE TO R hemiparesis | | 3 days
3 months
2 years | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-11-1966 to 4-18-1966 that (I) (we) last saw the deceased alive on 4-18-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Alan E. Oestrich | | | | 23B. DATE SIGNED
4/18/66 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. ALAN E. OESTRICH | | | | 23D. ADDRESS
4940 EASTERN AVENUE #21224
Baltimore City Hospitals | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/22/66 | | 24C. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | |
| 24D. LOCATION (City, town, or county)
BALTIMORE, MARYLAND | | 24E. FUNERAL DIRECTOR
Robert E. Altman
Funeral Home Inc. 6009 HARFORD RD | | 24F. ADDRESS | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 21 1966 | | 25B. NAME OF REGISTRAR
Robert E. Altman | | 25C. FUNERAL DIRECTOR
Robert E. Altman | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04081 | |
|---|--------------|--|------------------------------|--|---|
| BIRTH NO. 66 04081 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Williams Benjamin | | 2. DATE AND HOUR OF DEATH
April 20 1966 4:40 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION
University Hospital | | D. STREET ADDRESS (If rural, give location)
1329 N. Fulton St. | | E. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| 5. SEX
M | 6. RACE
C | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
11/14/90 | 9. AGE (In years last birthday)
75 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
- |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
- | | 10B. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Robert H. Williams | | 14. MOTHER'S MAIDEN NAME
Mary M. Wilkerson | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
- | | 16. SOCIAL SECURITY NO.
216-03-9257 | | 17. INFORMANT
W. PC | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
540.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Hypertensive Cardiovascular disease | | CAUSE OF DEATH
(A) Acute Renal Failure
DUE TO
(B) Transfusion Reaction
DUE TO
(C) Bleeding Gastric Ulcer
with severe Gastroenteropathy | | INTERVAL BETWEEN ONSET AND DEATH
4 days
5 days
8 days | |
| 19A. DATE OF OPERATION
4/14/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Bleeding Gastric Ulcer | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
<input type="checkbox"/> | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
<input type="checkbox"/> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<input type="checkbox"/> | |
| 22. I certify that (I) (this hospital) attended the deceased from April 13 1966 to April 20 1966, that (I) (we) last saw the deceased alive on April 20 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Harold C. Standiford | | | | 23B. DATE SIGNED
4/20/66 | |
| 23C. PHYSICIAN'S NAME (Type)
Harold C. Standiford | | | | 23D. ADDRESS
M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/23/66 | | 24C. NAME OF CEMETERY OR CREMATORY
Mt. Auburn | |
| 24D. LOCATION
Baltimore | | 24E. CITY, TOWN, OR COUNTY
Md | | 24F. STATE
Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 21 1966 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
V. Brooks Ruggold | |
| 25D. ADDRESS
1463 N. Carey St | | 25E. CITY, TOWN, OR COUNTY
Baltimore | | 25F. STATE
Md | |

Handwritten signature

April 20

April 19

April 18

April 17

4/17/60 Breeding season starts

Myxomatosis - the disease

~~Bleeding Gastric Ulcer~~

Transfusion Reaction

Acute Renal Failure

W. 40

Gray M. Williams

Maryland

4/14/60 20

March

University of Maryland

1220 N. Fulton St

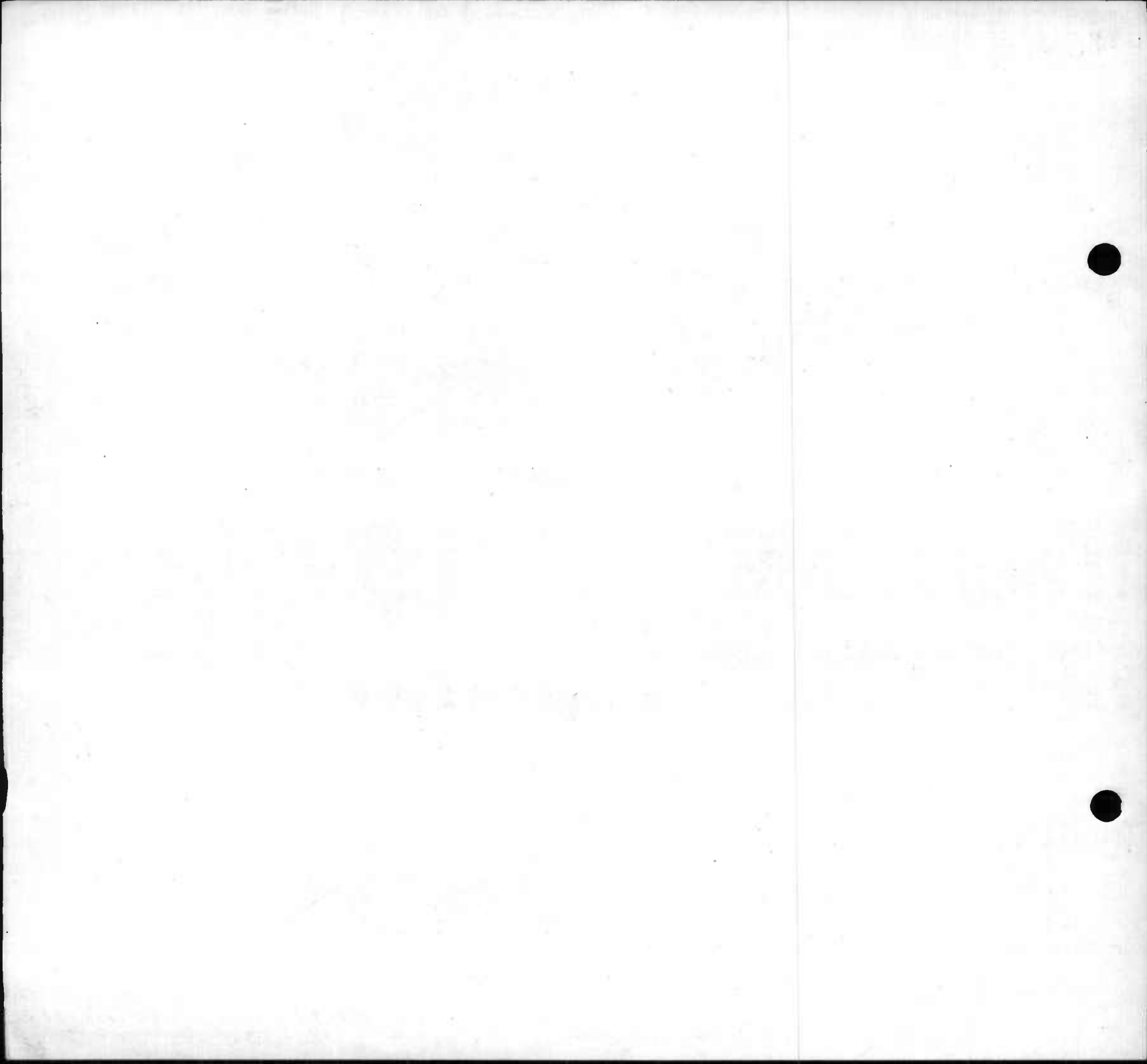
Baltimore

Maryland

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 66 04082 | |
|--|-----------|--|--------------------------|--|--------------------------------|--|---------------------------------|
| BIRTH NO. 66 04082 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) FLORA B. WHIMS (WHIMINS) | | 2. DATE AND HOUR OF DEATH 4-20-66 6:30 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIV. HOSP. REDWOOD & GREENE | | | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. | | | |
| 6. STREET ADDRESS (If rural, give location) 725 GEORGE | | | | 7. APARTMENT NO. APT 13 | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 4-18-95 | 9. AGE (In years last birthday) 71 | 10. If Under 1 Yr. Months Days | | 11. If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas Davis | | | | 14. MOTHER'S MAIDEN NAME Annie Barrett | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT OSCAR WHIMS | | ADDRESS 725 GEORGE ST | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) Myocardial infarct. complete & infarcted. | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 4-19 1966 to 4-20 1966, that (1) (we) last saw the deceased alive on 4-20 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Gary Lee Nobel | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 4/20/66 | |
| 23C. PHYSICIAN'S NAME (Type) GARY LEE NOBEL | | | | 23D. ADDRESS 6851-C STORBRIDGE BALTO MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4/23/66 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Co | | 24D. LOCATION (City, town, or county) (State) Anne Arundel City, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 21 1966 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR Wm March | | ADDRESS 928 E. North Ave | |



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D500

66 04083

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 04083

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

CARLEAN (CAROLYN) DUNN

2. DATE AND HOUR PRONOUNCED DEAD

April 19, 1966

7:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1204 E. Eager Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

Oct 7, 1909

9. AGE (In years
last birthday)

56

10. Under 1 Yr. 11 Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Thomas Williams

14. MOTHER'S MAIDEN NAME

Mary Lou

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Mary Quarles 620 St. Ann Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Left upper lobe lobar pneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.Fatty infiltration of liver
Partial

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-19-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/22/66

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 21 1966

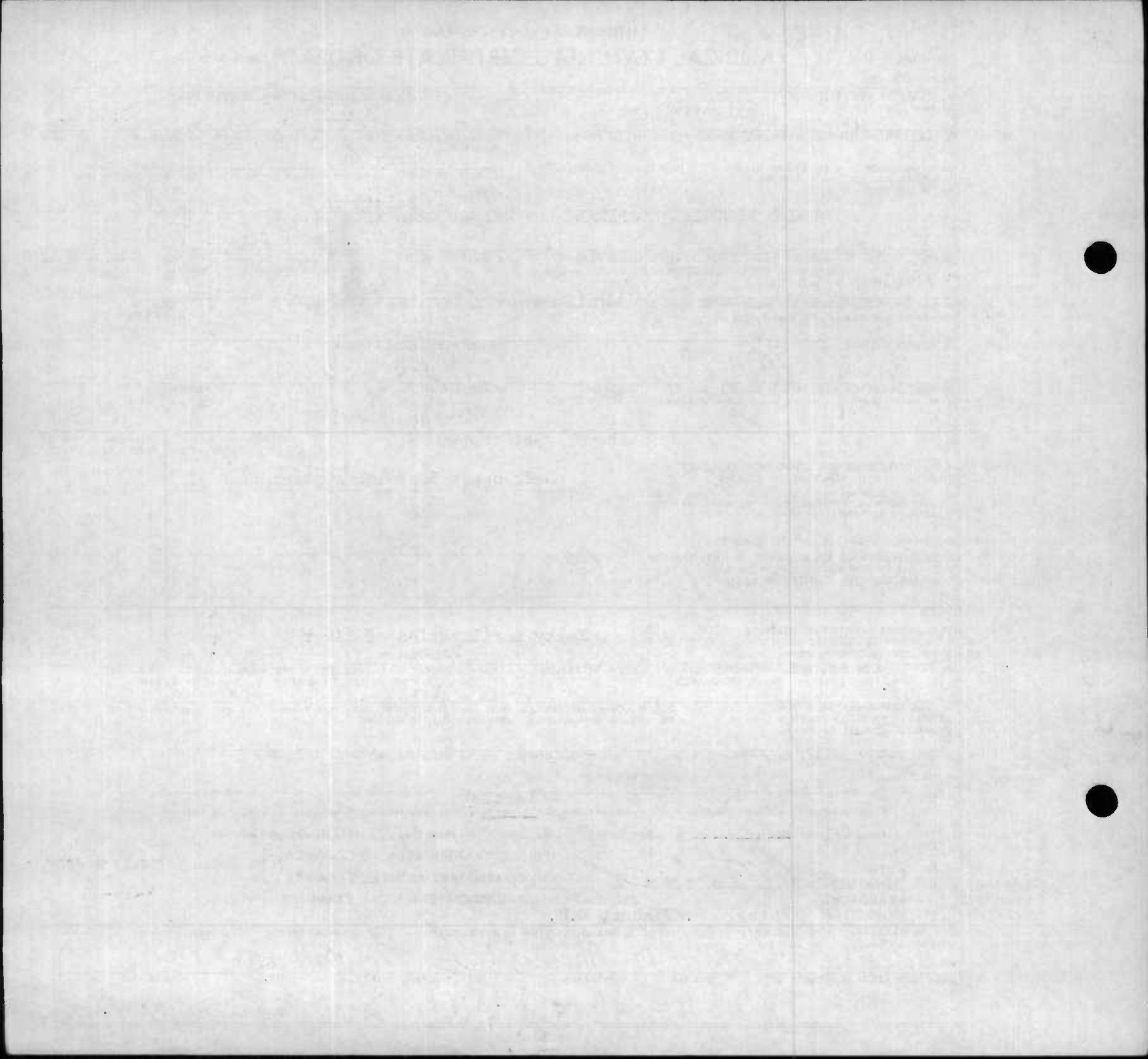
24B. NAME OF REGISTRAR

Robert E. Jenkins

24C. FUNERAL DIRECTOR

ADDRESS

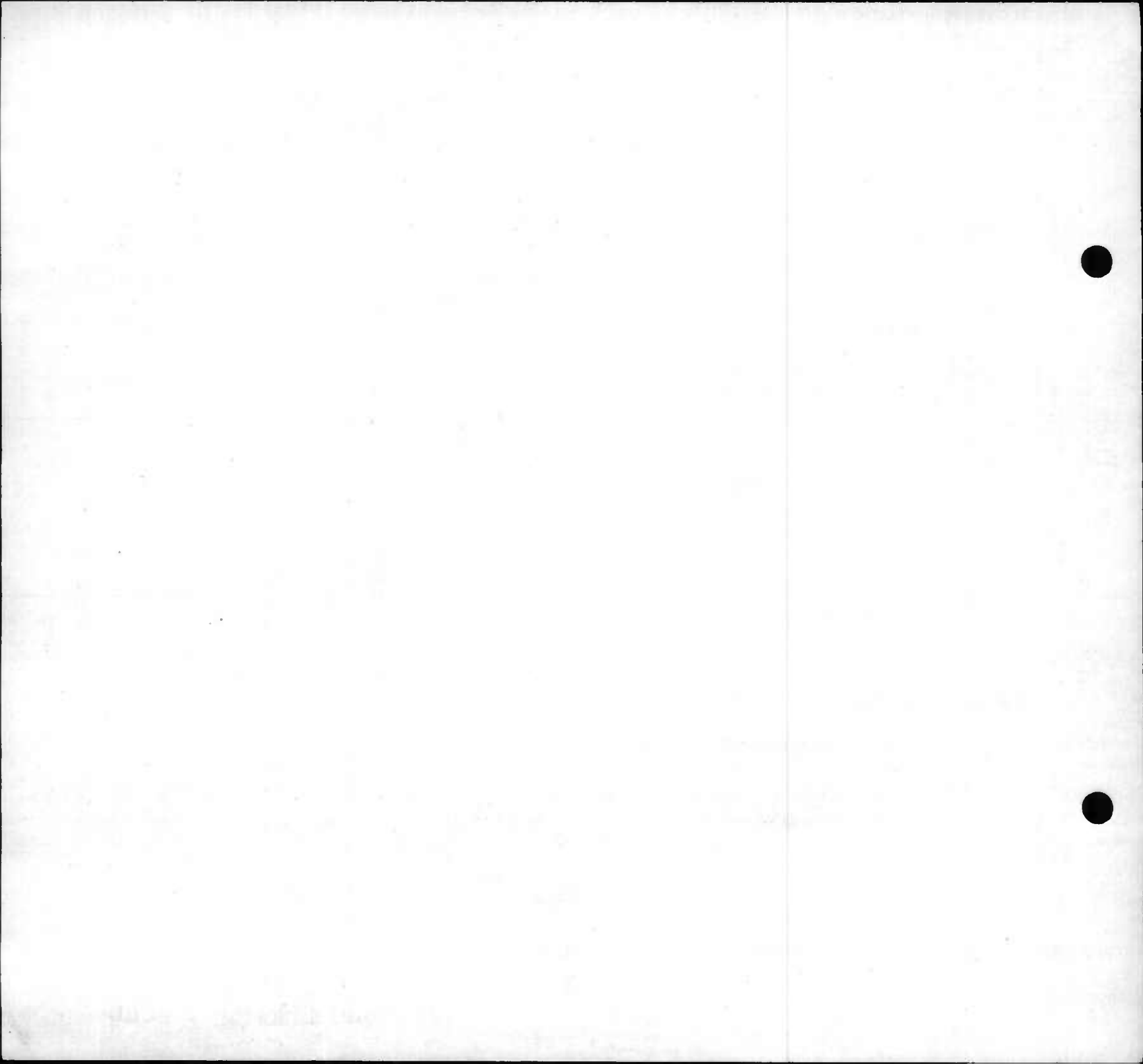
Wm. March 928 E. North Ave



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 04084</u> | |
|---|---------------------------|---|---------------------------------|---|---|
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) <u>Saunders, Alvin</u> | | 7:35 p.m. April 12, 1966 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>UNIVERSITY Hospital</u>
<u>Baltimore 1, Md.</u> | | A. STATE <u>Maryland</u>
B. COUNTY <u>Anne Arundel</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Steen Burnie</u>
D. STREET ADDRESS (If rural, give location) <u>7355 Furnace Branch Road</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>Colored</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>?</u> | 8. DATE OF BIRTH
<u>1901</u> | 9. AGE (In years last birthday)
<u>65</u> <u>66</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>NURSING HOME PATIENT</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>unk</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>?</u> | | 13. FATHER'S NAME
<u>unk</u> | | 14. MOTHER'S MAIDEN NAME
<u>unk</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>?</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. <u>420.1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <u>Congestive Heart Failure</u>
DUE TO
(B) <u>Myocardial Infarction</u>
DUE TO
(C) <u>Generalized Atherosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>pyelonephritis, atherosclerotic cerebral vasculardisease</u>
<u>Chronic granuloma inguinale</u> | | | |
| 19A. DATE OF OPERATION
<u>NO</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<u>NO</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3-17</u> 19 <u>66</u> to <u>4-12</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4-12</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>John Coffey</u> M.D. | | | | 23B. DATE SIGNED
<u>4-12-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
<u>UNIVERSITY HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<u>APR 21 1966</u> | | 24C. NAME OF CEMETERY
<u>UNIVERSITY MEDICAL SCHOOL</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 21 1966</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Jenkins</u> | | 25C. FUNERAL DIRECTOR
<u>MORTUARY SERVICE - BCHA</u> | |



66 04085

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04085

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RUSSELL HOLLYDAY

2. DATE AND HOUR PRONOUNCED DEAD

4-3-66

4:50 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

FRANKLIN SQUARE HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

109 N. Carey Street 21223

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S

NAME (Type) WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-4-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

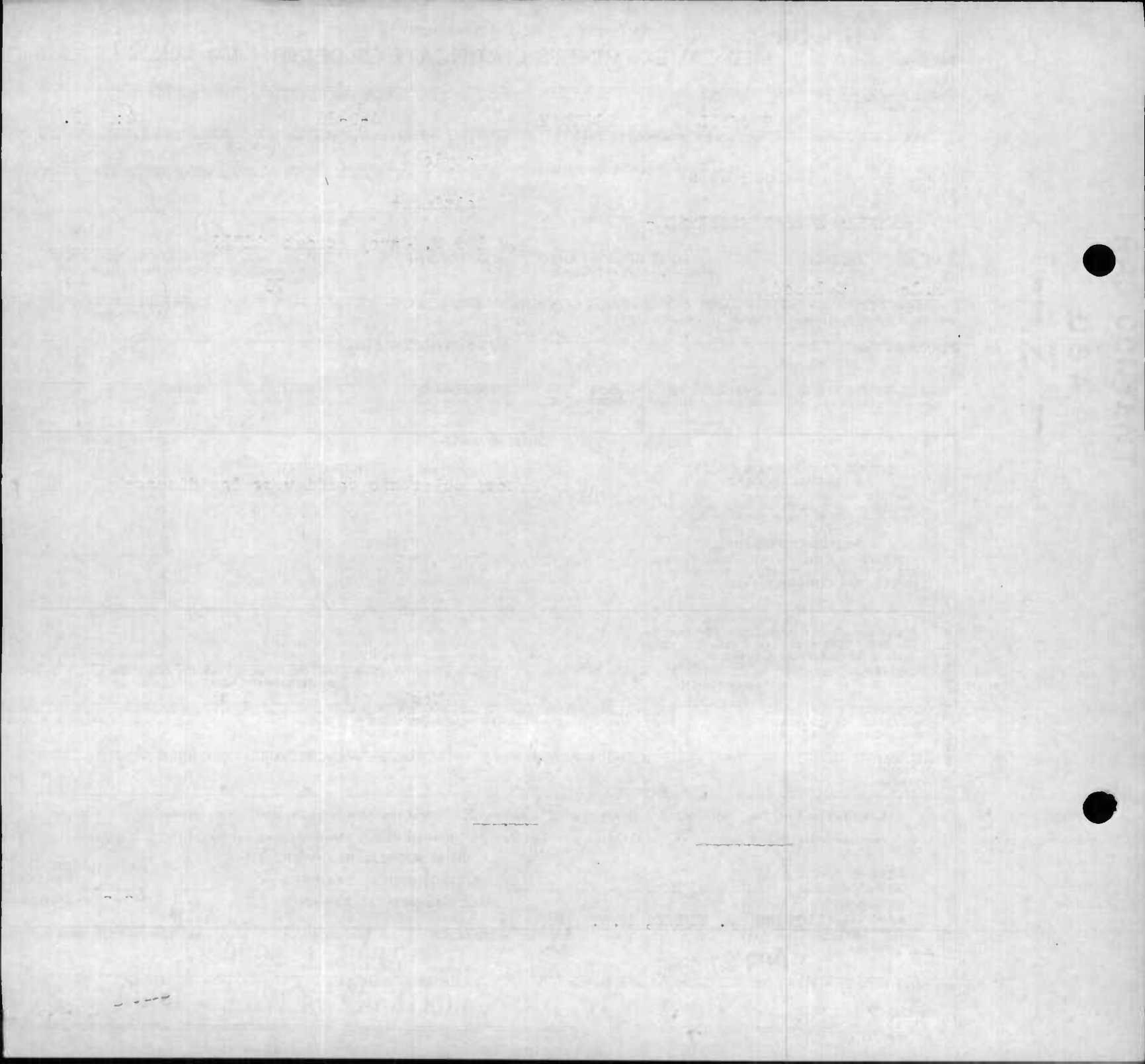
24C. FUNERAL DIRECTOR

ADDRESS

APR 21 1966

APR 21 1966

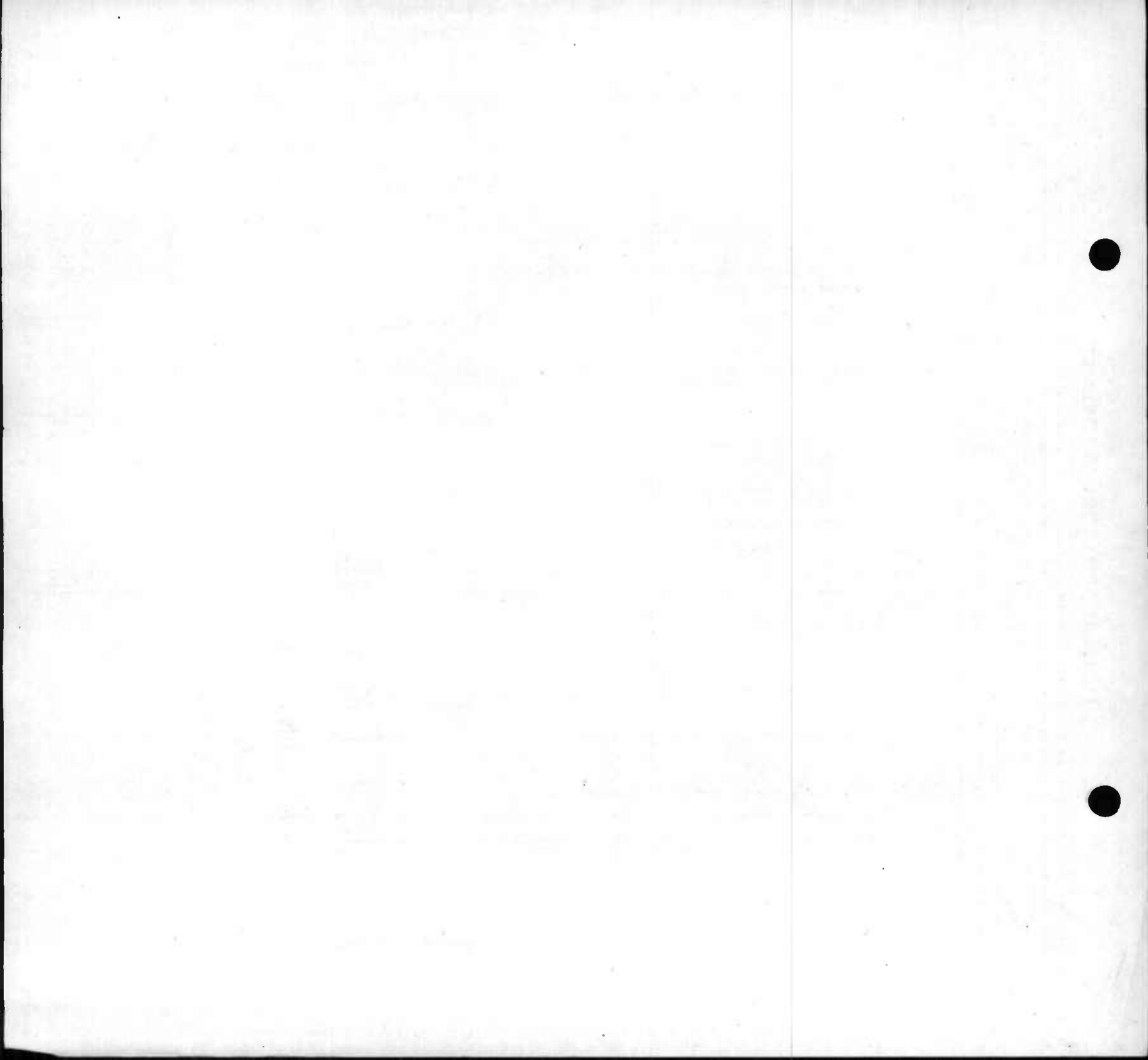
MORTUARY SERVICE - BCHD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

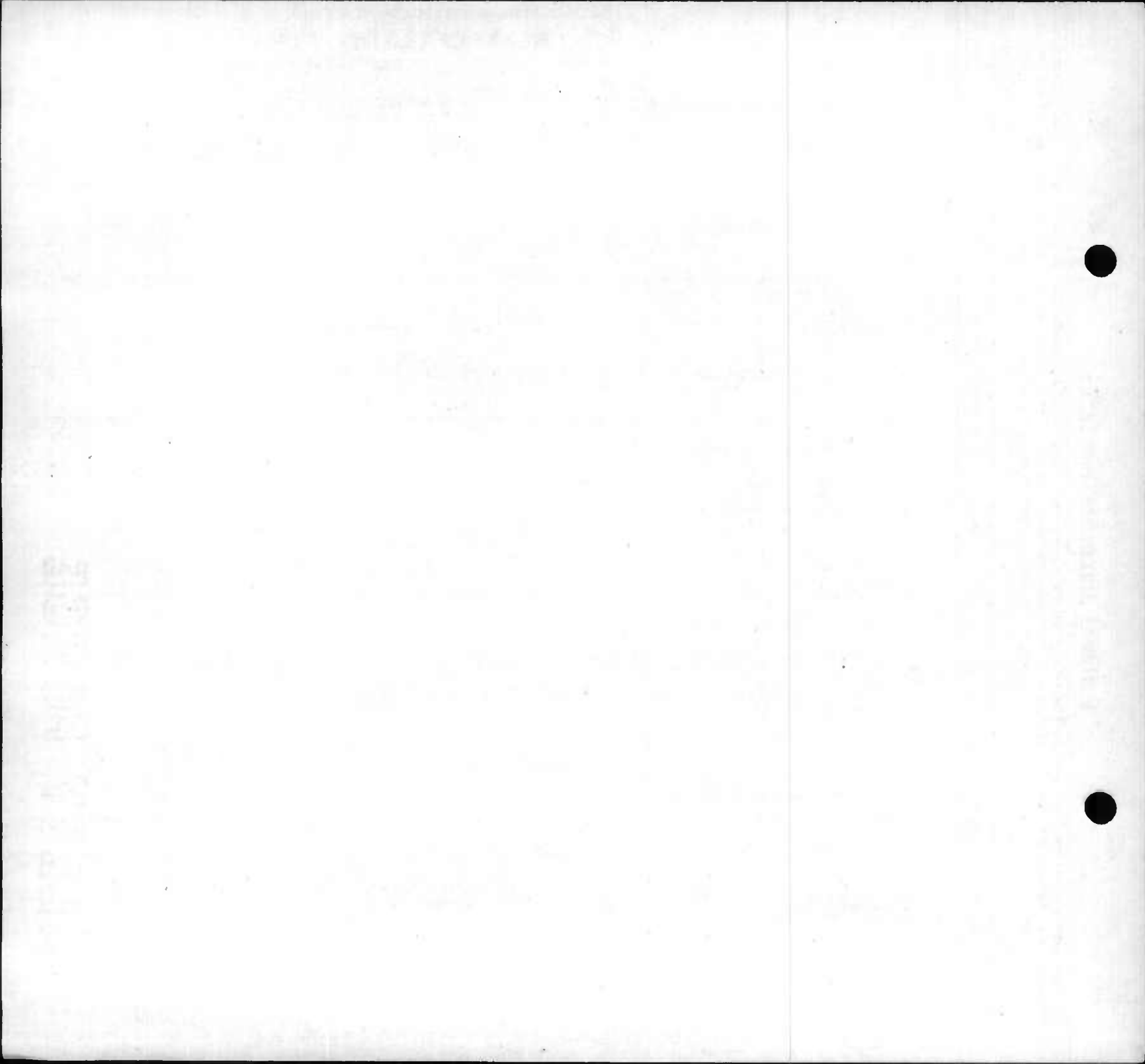
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|--|--|-----------|--|--|----------------------|--------------------------|--|---------------------------------|--|--|--|-----------------------------|--|--|--|--|--|--|--|
| BIRTH NO. 66-0792966 04086 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 04086 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | 2. DATE AND HOUR OF DEATH | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) BABY BOY RAY "A" | | | | | | | | | | 4-15-66 7 ³⁰ A. M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
UNIVERSITY HOSPITAL | | | | | | | | | | A. STATE MD. B. COUNTY 8-03 | | | | | | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | | | | | | BALTO. | | | | | | | | | |
| D. STREET ADDRESS (If rural, give location) | | | | | | | | | | 1301 KEN HILL AVE. #13. | | | | | | | | | |
| 5. SEX M | | 6. RACE N | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEONATE | | 8. DATE OF BIRTH 4-15-66 | | 9. AGE (In years last birthday) | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEONATE | | | | | | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| 11. BIRTHPLACE (State or foreign country) MD. | | | | | | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | |
| 13. FATHER'S NAME ? | | | | | | | | | | 14. MOTHER'S NAME SANDRA GAIL RAY. | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | | | | | | | 16. SOCIAL SECURITY NO. 0 | | | | | | | | | |
| 17. INFORMANT | | | | | | | | | | ADDRESS CHART # 32-76-56. | | | | | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | CAUSE OF DEATH (A) IMMATURITY (B) DUE TO (C) DUE TO | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 8 3/4 HRS. | | | | | | | | | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | | | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 20A. AUTOPSY? (Yes or No) NO | | | | | | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | | | | | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | | | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | | | | | | | | | | | | | | | |
| 22. I certify that (if at this hospital) attended the deceased from 4-15-66 to 4-15-66, that (if we) last saw the deceased alive on 4-15-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE Albert M. Gordon | | | | | | | | | | 23B. DATE SIGNED 4-15-66 | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) ALBERT M. GORDON | | | | | | | | | | 23D. ADDRESS UNIV. HOSP | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) APR 21 1966 | | | | | | | | | | 24B. DATE APR 21 1966 | | | | | | | | | |
| 24C. NAME OF CEMETERY OR CREMATORY ANATOMY BOARD OF MARYLAND | | | | | | | | | | 24D. LOCATION (City, town or county) (State) | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 21 1966 | | | | | | | | | | 25B. NAME OF REGISTRAR Robert E. Fisher | | | | | | | | | |
| 25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL | | | | | | | | | | ADDRESS | | | | | | | | | |
| MORTUARY SERVICE - BCHD | | | | | | | | | | | | | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 66 04087 | |
|--|--|--|--|--|--|--|--|
| BIRTH NO. 66 07930 66 04087 | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) BABY BOY RAY "B" | | | | 2. DATE AND HOUR OF DEATH 4-15-66 7:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSP. | | | | A. STATE MD. B. COUNTY 803 | | | |
| 5. SEX M 6. RACE N 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEONATE | | | | 8. DATE OF BIRTH 4-15-66 | | 9. AGE (In years last birthday) 8 8 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEONATE | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD. | |
| 13. FATHER'S NAME ? | | | | 14. MOTHER'S MARRIED NAME SANDRA GAIL RAY. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT HOSP. CHART # 32-76-56. ADDRESS | |
| 18. 776 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) IMMATURITY | | | | INTERVAL BETWEEN ONSET AND DEATH 8 5/60 HRS. | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-15 19 66 to 4-15 19 66, that (I) (we) last saw the deceased alive on 4-15 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Albert M. Gordon | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 4-15-66. | |
| 23C. PHYSICIAN'S NAME (Type) ALBERT M. GORDON M.D. | | | | 23D. ADDRESS UNIV. HOSP. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE APR 21 1966 | | 24C. NAME OF CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND | | 24D. LOCATION (City, town or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 21 1966 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR ADDRESS | | MORTUARY SERVICE - BCHD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

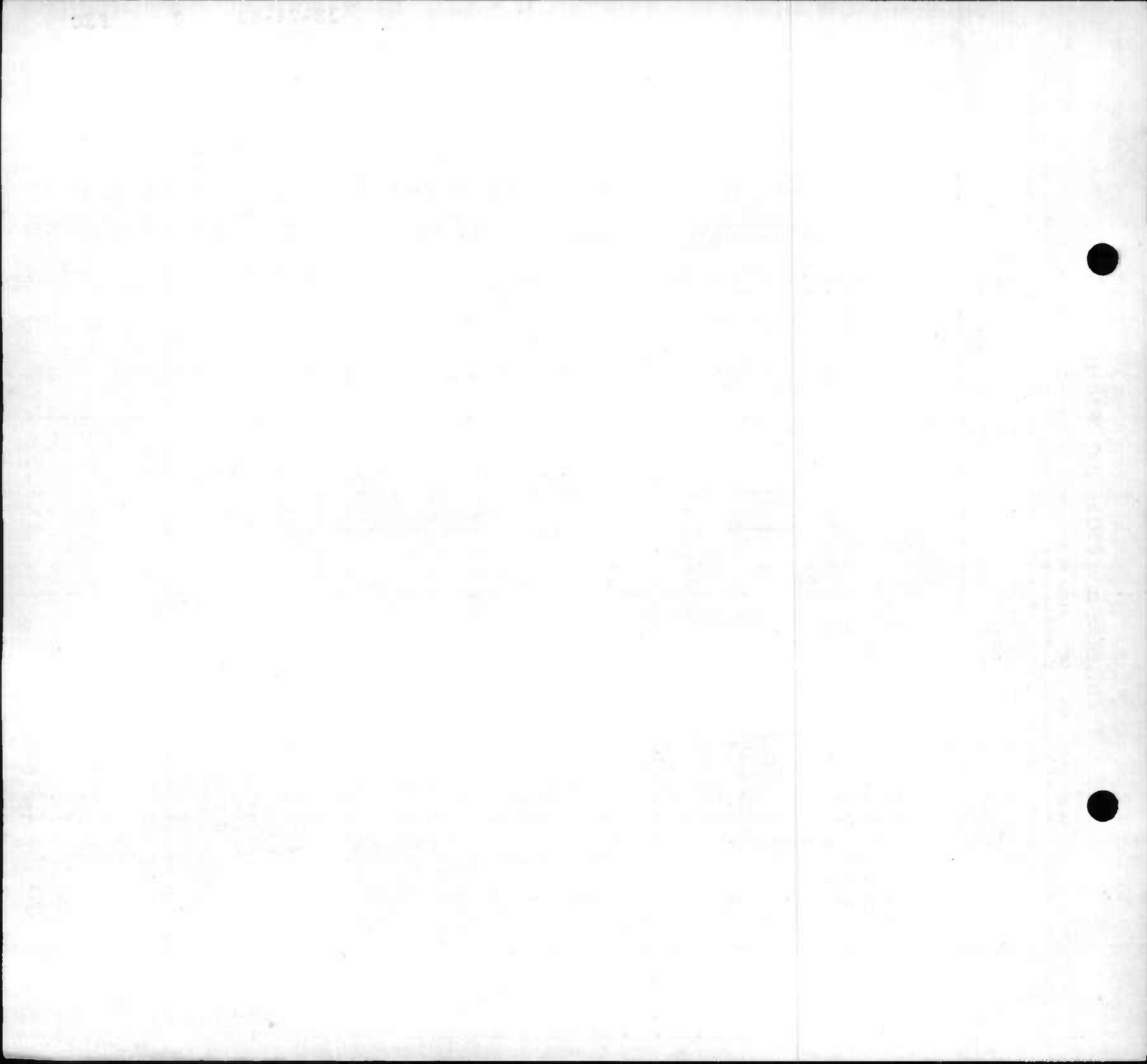
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 32-74-38 | | PNO | |
|---|-------------------------|---|-----------------------------------|---|----------------------------|---|--|
| BIRTH NO. 66-07455 66 04088 | | | | REGISTERED NO. 66 04088 | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) BABY BOY CHAPMAN | | | | 2. DATE AND HOUR OF DEATH
APRIL 8, 1966 19¹³ A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
UNIVERSITY HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 19-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
222 S. CALHOUN STREET | | | |
| 5. SEX
M | 6. RACE
CAUC. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
4/8/66 | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
INFANT | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MD. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
TOMMY JOE CHAPMAN | | | | 14. MOTHER'S MAIDEN NAME
DOROTHY JAKUBOWSKI | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
HOSP. RECORD 32-74-38 | | ADDRESS | |
| 18. 726X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

I (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) PREMATURITY
DUE TO
(B)
DUE TO
(C)
INTERVAL BETWEEN ONSET AND DEATH
6 hr. 47 min. | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/8/66 19 to 4/8 19 66 , that (I) (we) last saw the deceased alive on 4/8 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
M.B. Keeler | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/8/66 | |
| 23C. PHYSICIAN'S NAME (Type)
MARY BETH KEELER | | | | 23D. ADDRESS
UNIVERSITY HOSPITAL BALTIMORE, MARYLAND | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
CITY | | 24B. DATE
APR 21 1966 | | 24C. NAME OF CEMETERY OR CREMATORY
UNIVERSITY MEDICAL SCHOOL | | 24D. LOCATION (City, town or county) (State)
BALTIMORE MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 21 1966 | | 25B. NAME OF REGISTRAR
Robert E. Jenkins | | 25C. FUNERAL DIRECTOR
MORTUARY SERVICE - BCHO | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 04089 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04089 | |
|---|-------------------------|--|---|--|------------------------------|---|---------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print)
Theodore J. Van Leeuwen | | | | 2. DATE AND HOUR OF DEATH
April 19, 1966 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Sinai Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE Maryland
B. COUNTY 27-18
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
5205 Wilton Heights Ave. 15 | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
May 15, 1879 | 9. AGE (In years last birthday)
86 | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Shirt Ironer | | 10B. KIND OF BUSINESS OR INDUSTRY
Marlboro Shirt Co. | | 11. BIRTHPLACE (State or foreign country)
Holland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Theodore Van Leeuwen | | | | 14. MOTHER'S MAIDEN NAME
? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-10-5303 | | 17. INFORMANT
Mrs. Alma B. Horan same address as above | | | ADDRESS |
| 18. 260X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) Cerebral Vascular Accident
DUE TO
(B) Diabetes
DUE TO
(C) Generalized Arteriosclerosis | | | | INTERVAL BETWEEN ONSET AND DEATH
1 day
25 yrs
10 yrs | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
None | | | | | | | |
| 19A. DATE OF OPERATION
None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
None | | 20A. AUTOPSY? (Yes or No)
None | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
None | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Profound death at Sinai Hospital | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
Jan 1940 | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Profound death at Sinai Hospital | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1940 19 to April 18 19 66 , that (I) (we) last saw the deceased alive on April 18 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Milton E. Lowman | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4-21-66 | |
| 23C. PHYSICIAN'S NAME (Type)
MILTON E. LOWMAN | | | | 23D. ADDRESS
4843 PARK HEIGHTS AVE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/22/1966 | | 24C. NAME OF CEMETERY or CREMATORY
Woodlawn Cemetery | | 24D. LOCATION (City, town, or county) (State)
Woodlawn, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 21 1966 | | 25B. NAME OF REGISTRAR
Robert E. Jenkins | | 25C. FUNERAL DIRECTOR
Wm. J. Fickner & Sons | | | |
| | | | | ADDRESS
Balto Md. north Hpa. | | | |

Central Bank
Branch
Thompson's Building
New York

and some other

agencies for the
purpose of
investigating

Walter P. Brown
at 1 Park Hotel
4-21-33

66 04090

BALTIMORE CITY HEALTH DEPARTMENT

66 04090

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ALONZO BERNARD

2. DATE AND HOUR PRONOUNCED DEAD

April 20, 1966

6:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

PROVIDENT HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4417 Wentworth Rd.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Sept 15 1933

9. AGE (In years
last birthday)

32

If Under 1 Yr. If Under 24 Hrs.
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Tractor Operator

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ernest Bernard

14. MOTHER'S MAIDEN NAME

Ethel Galloway

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

yes

16. SOCIAL
SECURITY NO.

216-38-3109

17. INFORMANT

ADDRESS

Mrs. Ethel Galloway 701 N. Rosedale St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Sepsitemia
DUE TO fracture of right leg

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

building

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1021 Penna. Ave.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
4/15/66

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

jumped out of window

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-20-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4-25-66

23C. NAME OF CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

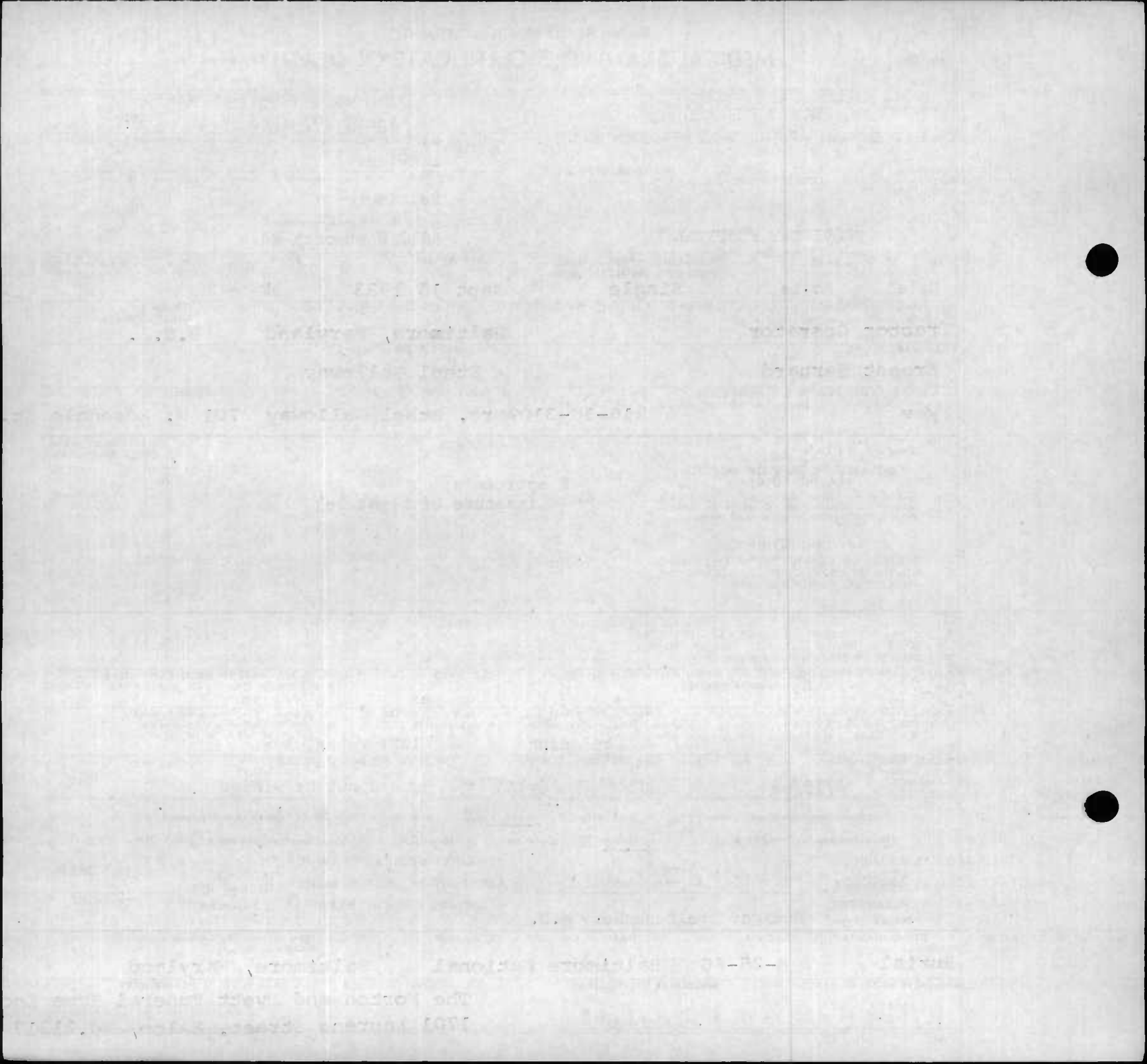
24C. FUNERAL DIRECTOR

ADDRESS

APR 21 1966

The Morton and Dyett Funeral Home Inc

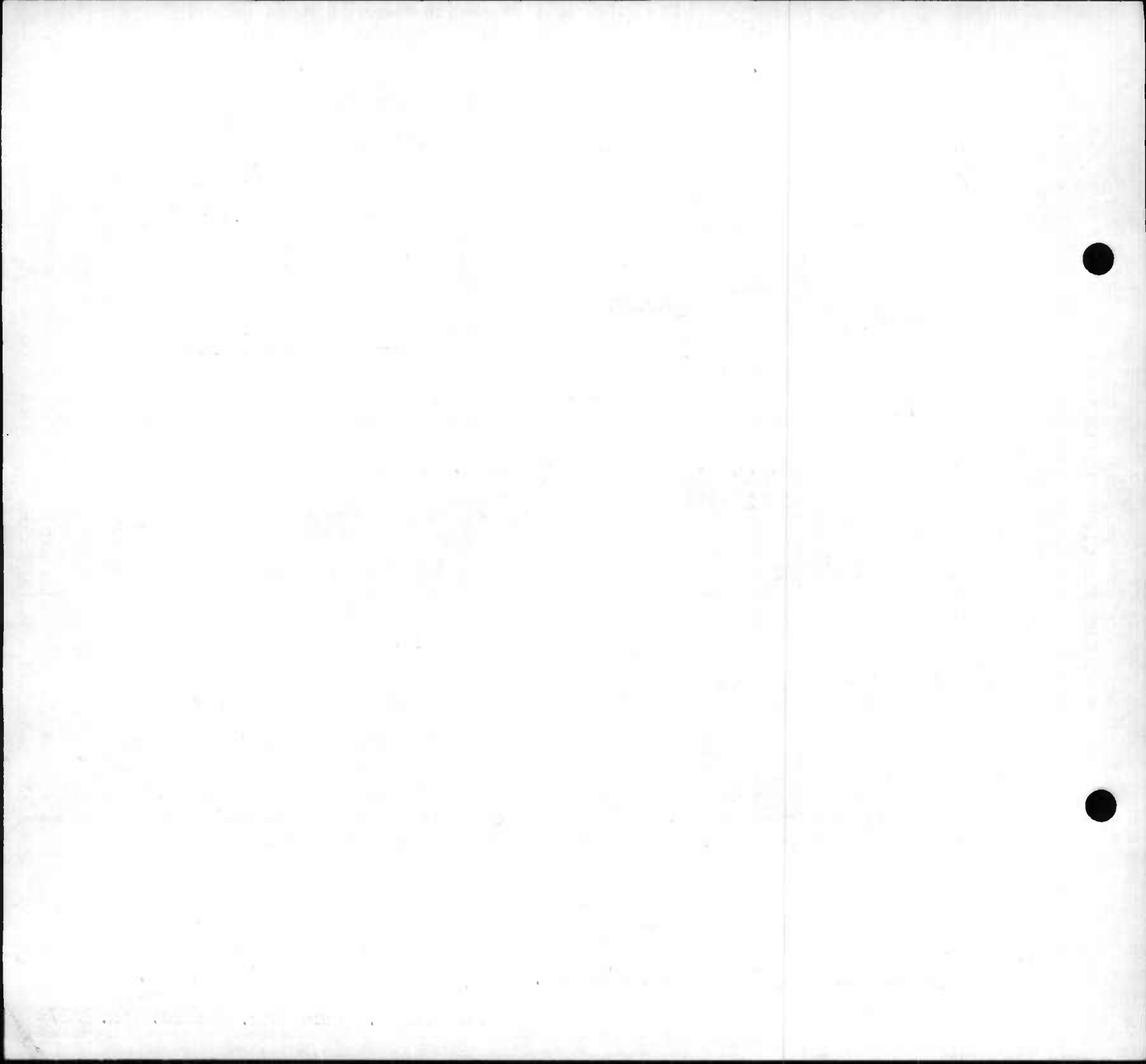
1701 Laurens Street. Balto, Md. 21217



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 66 04091 | |
|---|-----------|--|-------------------------|--|--|--|--|
| BIRTH NO. 66 04091 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) HERMAN R. KASCHNER | | 2. DATE AND HOUR OF DEATH 4/20/66 12:15 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 481 HARTLAND GENERAL | | | | A. STATE MARYLAND B. COUNTY 27-44 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE #14 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 3314 Echotule AVE | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 9/6/64 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY Grocer | | 11. BIRTHPLACE (State or foreign country) BALTO MD | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME HERMAN KASCHNER | | | | 14. MOTHER'S MAIDEN NAME Anna Trahe | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT AUGUST THIEL | | ADDRESS SAME | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 43 IX I | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO ABDOMINAL AORTIC ANEURYSM - ruptured | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO ARTERIO SCLEROSIS - GENERALIZED ASCVD + HCU | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) PROBABLE BRONCHOPNEUMONIA | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHRONIC EMPHYSEMA - | | | | | | | |
| 19A. DATE OF OPERATION 4/18/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED AORTIC ANEURYSM | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/17 1966 to 4/20 1966, that (I) (we) last saw the deceased alive on 4/20 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Donald Luedner | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 4/20/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Entombment | | 24B. DATE 4/23/66 | | 24C. NAME OF CEMETERY or CREMATORY Lorraine Pk. Mausoleum | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 21 1966 | | 25B. NAME OF REGISTRAR R. E. F. J. J. J. | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. | | ADDRESS Balto. Md. 21214 | |



66 04092

BALTIMORE CITY HEALTH DEPARTMENT

66 04092

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)M.
ROSE MELVILLE

2. DATE AND HOUR PRONOUNCED DEAD

April 19, 1966

3:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3004 Barclay St. - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3004 Barclay St.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Nov. 25, 1883.

9. AGE (In years
last birthday)

82

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Malachi Scalley

14. MOTHER'S MAIDEN NAME

Catherine Duke

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.
212-09-5714

17. INFORMANT

ADDRESS

Miss Irene E. Scalley 401 Calvin Ave. #18

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/20/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/23/66.

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 21 1966

Richard E. Jenkins

Leonard J. Ruck Inc. Balto. Md. 21214

WALTER DORRIS

Nov. 28, 1917

My dear Sir,

Enclosed find

215-02-1714 New York E. Corlies 401 Calver Ave. N.Y.

Respectfully,
Walter Dorris

New Cathedral Cemetery

Edward J. Buck Inc. N.Y. 21214

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 66 04093 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04093 | |
|--|-------------------------|--|---|---|---|--|---|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Rokel Katherine MRS KATE G. | | | | 2. DATE AND HOUR OF DEATH
4/20/66 - 3:20 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
35 Church Home and Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md. B. COUNTY
2903 NORTHERN PARKWAY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2903 E. Northern Parkway | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
11/29/03 | 9. AGE (In years lost birthday)
62 | If Under 1 Yr.
Months: Days: | If Under 24 Hrs.
Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (State or foreign country)
MD. - | | 12. CITIZEN OF WHAT COUNTRY?
AMERICAN |
| 13. FATHER'S NAME
George L. ALTWATER | | | | 14. MOTHER'S MAIDEN NAME
Kate Raumsaver | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
- | | 17. INFORMANT
Mr. Louis G. Rokel | | |
| | | | | | ADDRESS
(Same) | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
Pulmonary Embolism
(A) DUE TO
INTERVAL BETWEEN ONSET AND DEATH
minutes | | | | | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
Arterio-sclerotic Heart disease
Chronic leg ulcers, bilateral | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/5/66 19 66 to 4/20/66 19 66 that (I) (we) last saw the deceased alive on 4/20 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
[Signature] | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/20/66. | |
| 23C. PHYSICIAN'S NAME (Type)
A.E. Suborg | | | | 23D. ADDRESS
Church Home Hosp | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/23/66 | | 24C. NAME OF CEMETERY or CREMATORY
Parkwood Cemetery | | 24D. LOCATION (City, town or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 21 1966 | | 25B. NAME OF REGISTRAR
[Signature] | | 25C. FUNERAL DIRECTOR
J. J. Rack, Inc. | | ADDRESS
Balt., Md. | |

Philadelphia, Pa.

18

My dear Mr. Garrison

Dear Mr. Garrison

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|--------------|--|---|---|--|
| BIRTH NO.
66 04094 | | CERTIFICATE OF DEATH | | 66 04094 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print)
Julia Clarke | | | 2. DATE AND HOUR OF DEATH
4/16/66 9:35 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
Sinai Hospital of Baltimore. | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE
Maryland. B. COUNTY
Baltimore.
C. CITY OR TOWN
(If outside city limits, write RURAL and give township)
Baltimore.
D. STREET ADDRESS
(If rural, give location)
3500 Copley Rd. #15 | | |
| 5. SEX
F | 6. RACE
N | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
S. | 8. DATE OF BIRTH
9/28/13 | 9. AGE (In years last birthday)
52 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Teacher. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Teacher. | | 10B. KIND OF BUSINESS OR INDUSTRY
Balt. Cont. Board of Ed. | | 11. BIRTHPLACE (State or foreign country)
Virginia | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
— | | | 14. MOTHER'S MAIDEN NAME
— | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
— | | 16. SOCIAL SECURITY NO.
— | | 17. INFORMANT
Brother, William, Clarke | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
158X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH
(A) DUE TO
diffuse peritonitis
(B) DUE TO
gangrenous small bowel.
(C) DUE TO
carcinomatosis (due to Sarcoma). | | INTERVAL BETWEEN ONSET AND DEATH
36 hrs. | |
| 19A. DATE OF OPERATION
4/16/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
diffuse peritonitis | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
<input type="checkbox"/> | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)
<input type="checkbox"/> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<input type="checkbox"/> | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/16 1966 to 4/17 1966, that (I) (we) last saw the deceased alive on 4/17 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
David Zeitung | | | | 23B. DATE SIGNED
4/17/66 | |
| 23C. PHYSICIAN'S NAME (Type)
David Zeitung | | | | 23D. ADDRESS
Sinai Hospital of Baltimore. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-21-66 | | 24C. NAME OF CEMETERY OR CREMATORY
First United Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Gloucester, Virginia | | 25A. DATE REC'D BY HEALTH DEPT.
APR 21 1966 | | | |
| 25B. NAME OF REGISTRAR
R. E. Finkema | | 25C. FUNERAL DIRECTOR
George G. Nelson | | | |
| 25D. ADDRESS
1348 Calhoun St. | | | | | |

18 DEC 1974 MONTICELLO

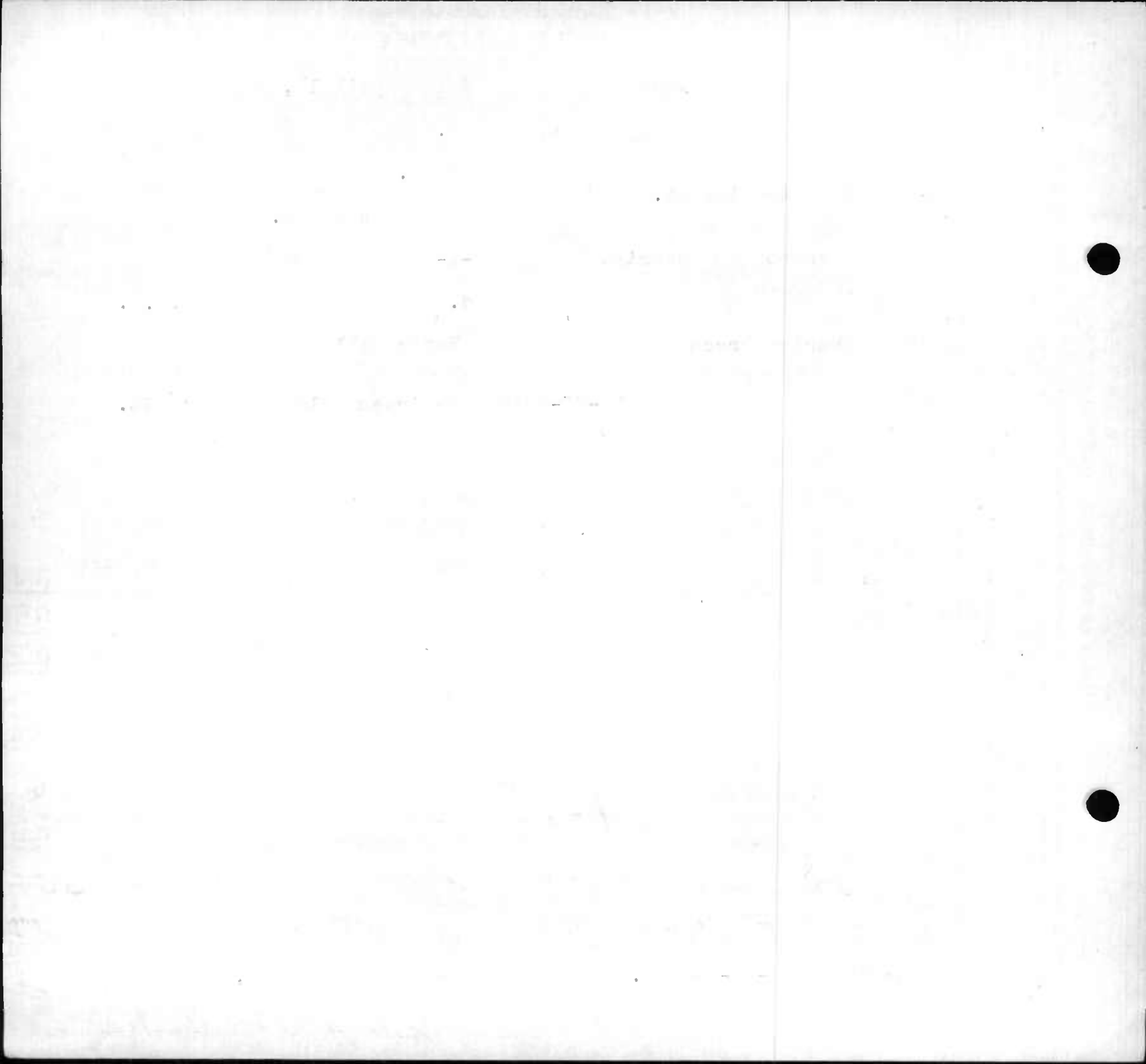
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

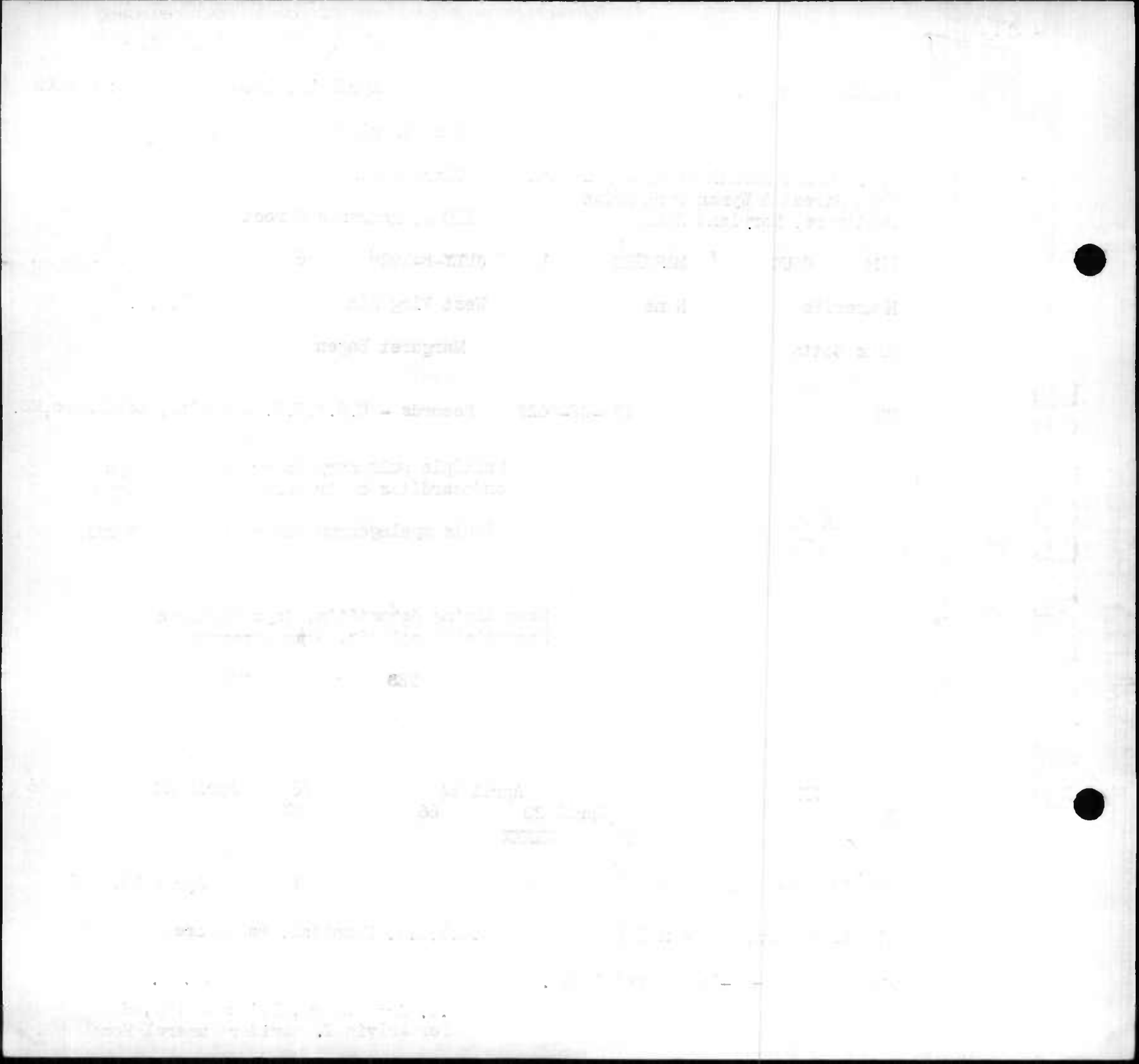
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|------------------------|--|--|--|---|--|---------------------------------|--|
| 66 04095 | | | | | 66 04095 | | | | |
| BIRTH NO. | | | | | REGISTERED NO. | | | | |
| M.E. CASE NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED
(Type or Print) Richard Green | | | | | April 18, 1966 M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | A. STATE B. COUNTY | | | | |
| 00 3106 Barkclay St. | | | | | Md. 1202 | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | |
| | | | | | Balto. | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) | | | | |
| | | | | | 3106 Barkclay St. Barclay | | | | |
| 5. SEX M | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| | | Negro | | married | | 2-1-00 | | 66 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | |
| | | | | | | | | | |
| 11. BIRTHPLACE (State or foreign country) | | | | | 12. CITIZEN OF WHAT COUNTRY? | | | | |
| Md. | | | | | U.S.A. | | | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | |
| Charles Green | | | | | Hattie Hall | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | |
| | | | | | 212-22-2219 | | | | |
| 17. INFORMANT | | | | | ADDRESS | | | | |
| Emma Green | | | | | 3106 Barkclay St. | | | | |
| 18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | CAUSE OF DEATH | | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) Cerebral Hemorrhage | | | | |
| | | | | | DUE TO | | | | |
| | | | | | Hypertensive Cardiovascular | | | | |
| ANTECEDENT CAUSES | | | | | (B) Arteriosclerosis Disease | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | DUE TO | | | | |
| | | | | | (C) Diabetes | | | | |
| | | | | | 10 years | | | | |
| | | | | | 8 years | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| | | | | | 20A. AUTOPSY? (Yes or No) | | | | |
| | | | | | No | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED | | | | |
| | | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from OCT - 1962 to April 19 - 1966, that (I) (we) last saw the deceased alive on 4-16-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | | 23B. DATE SIGNED | | | | |
| Robert F. Chenoweth M.D. | | | | | 4/21/66 | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS | | | | |
| ROBERT F. CHENOWETH M.D. | | | | | 1114 ST. PAUL ST BALTO, MD | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 4-23-66 | | Mt. Auburn Cemetery | | Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| APR 21 1966 | | Robert E. Fink | | George Wilson | | 1348 Calhoun St. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|------------------------|--|--|--|---|
| 66 04096 | | CERTIFICATE OF DEATH | | 66 04096 | |
| 1. NAME OF DECEASED
(Type or Print)
DILLOW, Mary Ann | | 2. DATE AND HOUR OF DEATH
April 20, 1966 12:00 NOON M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
U.S. Public Health Service Hospital
31st Street & Wyman Park Drive
Baltimore, Maryland 21211 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE West Virginia
B. COUNTY W-45
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Charlestown
D. STREET ADDRESS (If rural, give location)
110 S. Lawrence Street | | | |
| 5. SEX
FEM | 6. RACE
CAUC | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
JULY-8-1929 | 9. AGE (In years last birthday)
36 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
West Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Mike Cotta | | | |
| 14. MOTHER'S MAIDEN NAME
Margaret Bagent | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | |
| 16. SOCIAL SECURITY NO.
236-42-0625 | | 17. INFORMANT
Records - U.S.P.H.S. Hospital, Baltimore, Md. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoma, etc. It means the disease, injury or complication which caused death.)
2043 I
Multiple pulmonary infarcts
endocarditis of tricuspid | | CAUSE OF DEATH
(A) DUE TO
Multiple pulmonary infarcts
endocarditis of tricuspid
(B) DUE TO
Acute myelogenous leukemia
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
Days
Days
Months | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
Necrotizing dermatitis, days duration
Necrotizing colitis, days duration | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
YES | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that XX (this hospital) attended the deceased from April 14 19 66 to April 20 19 1966 , that X (we) last saw the deceased alive on April 20 19 66 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death. | | | | | |
| 23A. SIGNATURE
 | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
April 20, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
Thomas J. Lau, Surgeon (R) | | 23D. ADDRESS
M.D. U.S.P.H.S. Hospital, Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-23-1966 | | 24C. NAME OF CEMETERY or CREMATORY
Muriel Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Harpers Ferry, W.Va. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 22 1966 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
F.C. Higinbotham, Ellicott City, Md
for Melvin T. Strider Funeral Home | | | |



BIRTH NO. 66 04097 46-02004 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO. _____

| | | | | | |
|---|-------------------------|---|---|--|--|
| 1. NAME OF DECEASED
(Type or Print)
GEORGE Anthony SOKAL | | | 2. DATE AND HOUR PRONOUNCED DEAD
April 21, 1966 9:20 A M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

128 N. Kenwood Avenue | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY _____
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
128 N. Kenwood Avenue | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
January 27, 1966 | 9. AGE (In years last birthday)
3 | If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Alexander Sokal | | | 14. MOTHER'S MAIDEN NAME
Barbara Zack | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS
Alexander Sokal 128 N. Kenwood Ave | | |
| 18. 325 X I
CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (A) Interstitial Pneumonitis.
DUE TO | | |
| | | | (B) _____
DUE TO | | |
| | | | (C) _____ | | |
| | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
Yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22.
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>

ACTUAL SIGNATURE <i>Charles S. Petty</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) Charles S. Petty, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/21/66 | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
4/22/66 | 23C. NAME OF CEMETERY or CREMATORY
Sacred Heart Of Mary | | 23D. LOCATION (City, town, or county) (State)
Baltimore, County-Maryland |
| 24A. DATE REC'D BY HEALTH DEPT.
APR 22 1966 | | 24B. NAME OF REGISTRAR
<i>Robert E. Taylor</i> | | 24C. FUNERAL DIRECTOR ADDRESS
George A. Weber 705 South Ann Street | |

VACUUM JOINT

CERTIFICATE OF DEATH

Registered No. 66 04098

BIRTH NO. 66 04098

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BARAN, TEKKA - Tekla Baran

2. DATE AND HOUR OF DEATH

4/20/66 8:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street
address or location)

BALT. CITY HOSP

4940 Eastern Avenue, Balto. Md. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MD

Balto

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

53-00

D. STREET ADDRESS (If rural, give location)
6512 OLD WASHINGTON RD, 21227

5. SEX

F

6. RACE

W.

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

11-1-93

9. AGE (In years
lost birthday)

72-12

10. If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

H.W.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

POLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

FLORIAN KAWA

14. MOTHER'S MAIDEN NAME

CATHERINE KADULSKI

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.17. INFORMANT
ADDRESS
RECORDS: BCH 4940 Eastern Avenue, Balto. Md. 21224
JOSEPH BARAN. H.A.

18. 491X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Pneumonia

15 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO

? Aspiration

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Cerebral Arteriosclerosis & Stenosis

2 yrs

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)21E. INJURY OCCURRED
While At Not While
Work At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 8/17/62 19 to 4/20/66 19
that (we) last saw the deceased alive on 4/20/66 19 and that in (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (did) (did not) view the body after death.

23A. SIGNATURE

Conferdach

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

4/20/66

23C. PHYSICIAN'S
NAME (Type)

A.I. MURDOCK

M.D.

23D. ADDRESS

4940 Eastern Avenue, Balto. Md. 21224
BALT. CITY HOSP24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

4/23/66

24C. NAME OF CEMETERY OR CREMATORY

St. Augustine's Cemetery

24D. LOCATION

Elkridge, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

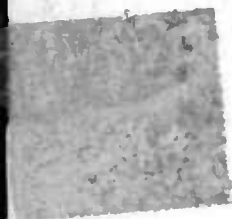
ADDRESS

George A. Weber 705 S. Ann St

APR 22 1966 April 2, 1966

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



1105A

1105A 1105A

1105A 1105A

BIRTH NO. 66-020031 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

| | | | | | | | |
|---|-------------------------|--|---|---|---|--|--|
| 1. NAME OF DECEASED
(Type or Print)
MICHAEL Alexander SOKAL | | | | 2. DATE AND HOUR PRONOUNCED DEAD
April 21, 1966 9:20 A M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
128 N. Kenwood Avenue | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
128 N. Kenwood Avenue | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH
January 27, 1966 | 9. AGE (In years last birthday) | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.
3 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Alexander Sokal | | | | 14. MOTHER'S MAIDEN NAME
Barbara Zack | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Alexander Sokal 128 N. Kenwood Ave | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Interstitial Pneumonitis.
INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
4/22/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Charles S. Petty M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) Charles S. Petty, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/21/66 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
4/22/66 | | 23C. NAME OF CEMETERY or CREMATORY
Sacred Heart Of Mary | | 23D. LOCATION (City, town, or county) (State)
Baltimore, County-Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT.
APR 22 1966 | | 24B. NAME OF REGISTRAR
George A. Weber | | 24C. FUNERAL DIRECTOR ADDRESS
George A. Weber 705 South Ann Street | | | |

WALLLEY HONORABLE

HAD CONTENT

7-1

46-47-50
TS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| F-320 66 04100 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04100 | |
|--|---------|--|------------------|--|-----------------------------|---|------------------------------|
| BIRTH NO. | | | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | |
| FETZ, HENRY J | | | | 2. DATE AND HOUR OF DEATH
4/19 '66 11:55 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | MD | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| BALTIMORE CITY HOSPITAL | | | | BALTIMORE | | D. STREET ADDRESS (If rural, give location) | |
| 4940 Eastern Ave. - Balto, Maryland 21224 | | | | 329 Cornwell St. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | 12. CITIZEN OF WHAT COUNTRY? |
| Male | White | Married | 10/19 '97 | 68 | | | U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Stone-cutter | | | | MARYLAND | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Michael Feby | | | | Mathilda (2) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | | | 218-03-0733 | | 4940 Eastern Avenue | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | Acute myocardial infarction 3 days | | | |
| ANTECEDENT CAUSES | | | | ASCVD. | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | Pulmonary edema | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| No | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/18 1966 to 4/19 1966, that (I) (we) last saw the deceased alive on 4/19 '66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| H. Petrusson | | | | | | 4/19 '66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| MAGNUS KARL PETURSSON | | | | BALTIMORE CITY HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 4-22-66 | | St Stanislaus | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| APR 22 1966 | | Robert E. Gierke, M.D. | | Walter Dabrowski | | 1005 Dumbalk Ave. | |

BALTIMORE CITY HOSPITAL
BALTIMORE

M. W. M. W. M. W.
Maryland
Washington (S)

Porte unguentum infusum
ASCUD.

M. W. M. W. M. W.
BALTIMORE CITY HOSPITAL
BALTIMORE

BALTIMORE CITY HEALTH DEPARTMENT

66 04101

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

| | | | |
|--|--|---|---|
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| Hannah Jett | | 4/18/66 8:30 a. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital | | A. STATE
Maryland | |
| | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 1204 | |
| D. STREET ADDRESS (If rural, give location)
2305 N. Calvert St. | | | |
| 5. SEX
female | 6. RACE
colored | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
Apr. 12, 1891 |
| | | 9. AGE (in years last birthday)
75 | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
Home | 11. BIRTHPLACE (State or foreign country)
Berkeley County, W. Va. |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
Lewis Brown | | 14. MOTHER'S MAIDEN NAME
Susan | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
No | 17. INFORMANT ADDRESS
Mrs. Dorothy Johnson-Baltimore, Maryland |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease
(A) DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
NO |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| Werner U. Spitz, M.D. | | DATE SIGNED
4/18/66 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 23B. DATE
4-22-1966 | 23C. NAME OF CEMETERY or CREMATORY
Rose Hill Cemetery | 23D. LOCATION (City, town, or county) (State)
Shepherdstown, Jefferson, W. Va. |
| 24A. DATE REC'D BY HEALTH DEPT.
APR 22 1966 | 24B. NAME OF REGISTRAR
Robert E. Finkbeiner | 24C. FUNERAL DIRECTOR
Brown Funeral Home | ADDRESS
Martinsburg, W. Va., |

VS 151-REV. 1/1/65

VALLEY BOAT

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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 66 04102 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04102

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Harry H. Will

2. DATE AND HOUR PRONOUNCED DEAD

4/18/66 8:40 a. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3000 Matthews St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3000 Matthews St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

3/17/17

9. AGE (In years
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MECHANIC

10B. KIND OF BUSINESS OR INDUSTRY

MARTIN'S

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW II

16. SOCIAL
SECURITY NO.

215-07-9456

17. INFORMANT

ADDRESS

EVELYN WILL 3000 MATTHEWS ST.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Confluent bronchopneumonia, left lung
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/18/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

4/21/66

23C. NAME of CEMETERY or CREMATORY

NATIONAL

23D. LOCATION

(City, town, or county)

(State)

BALTO, MD.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 22 1966

Paul E. Spitz, M.D.

Paul E. Spitz, M.D. 3617 Chestnut Ave.

WALLACE R. FORD

[Handwritten signature]

CERTIFICATE OF DEATH

Registered No. 66 04103

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LAWRENCE JONES

2. DATE AND HOUR OF DEATH

15 Apr 66

1235 PM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4940 Eastern Avenue, Balto, Md. 21224

Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Baltimore

1207 Joplin St.

21224

5. SEX

Male

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

2-21-98

9. AGE (in years
lost birthday)

68

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Coal-miner (Retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

LAWRENCE W. JONES

14. MOTHER'S MAIDEN NAME

Liza Hume

15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown. If yes, give year or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Ave., Balto, Md. 21224

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., but means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above, (A) stating the UNDERLYING CONDITION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

CAUSE OF DEATH

CEREBRAL ANOXIA

MYOCARDIAL ARREST

Acute hypovolemia in Anesthesia

Poor myocardial reserve

Purulent Peritonitis

INTERVAL BETWEEN ONSET AND DEATH

Immediate

20 minutes

30 min

4+ days

MEDICAL CERTIFICATION

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 14 Apr 66 to 15 Apr 66. that (I) (we) last saw the deceased alive on 15 Apr 66 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

David F. Fairbanks M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

15 Apr 66

23C. PHYSICIAN'S NAME (Type)

DAVID F. FAIRBANKS M.D.

23D. ADDRESS

4940 Eastern Avenue, Balto, Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Removal

24B. DATE

4/19/66

24C. NAME OF CEMETERY OR CREMATORY

Oddfellows Cemetery

24D. LOCATION (City, town, or county)

Blaine, St. Va.

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 22 1966

25B. NAME OF REGISTRAR

Robert E. Fairbanks

25C. FUNERAL DIRECTOR

Connelly Sons 300 Macaulay Blvd

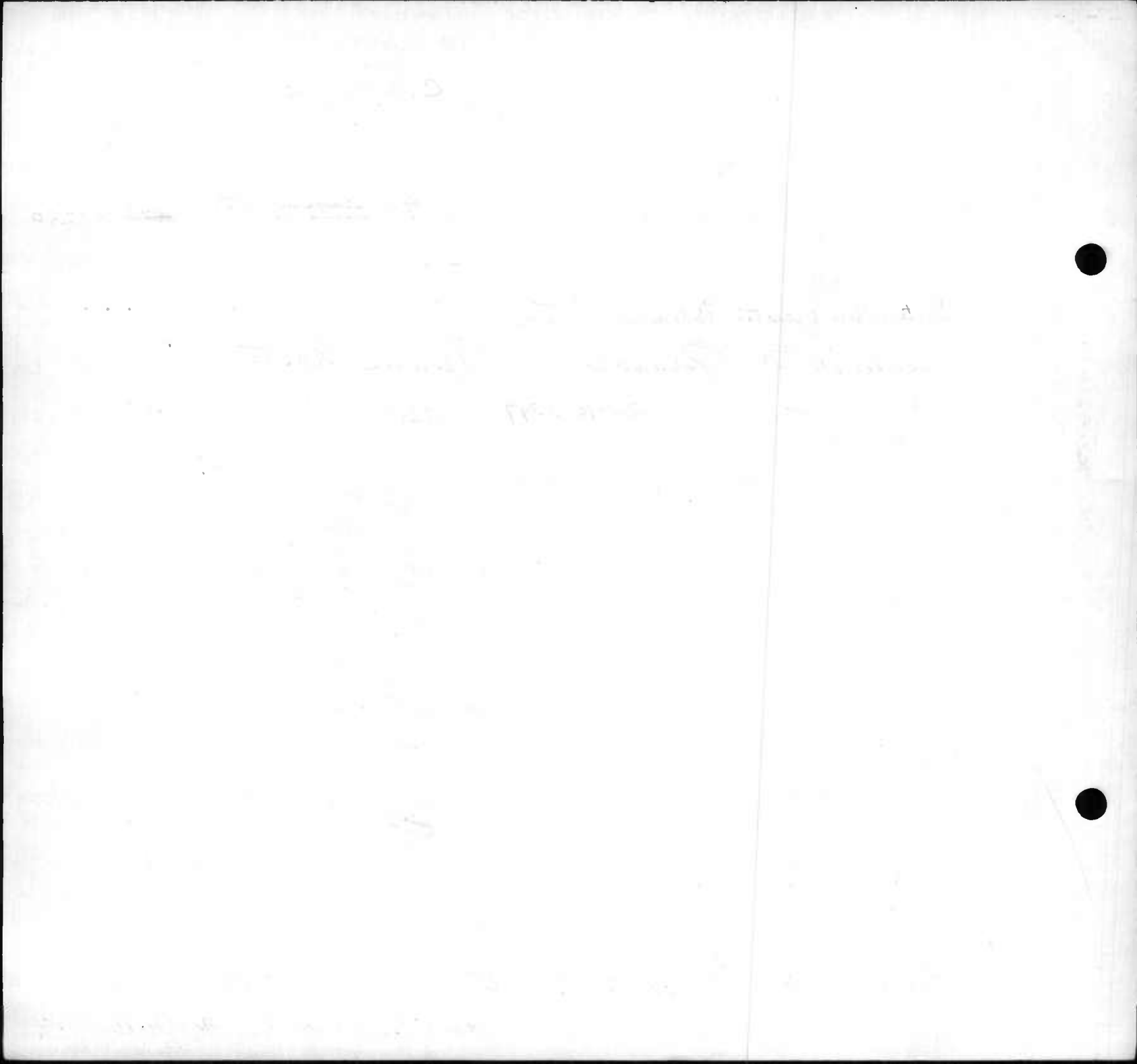
ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

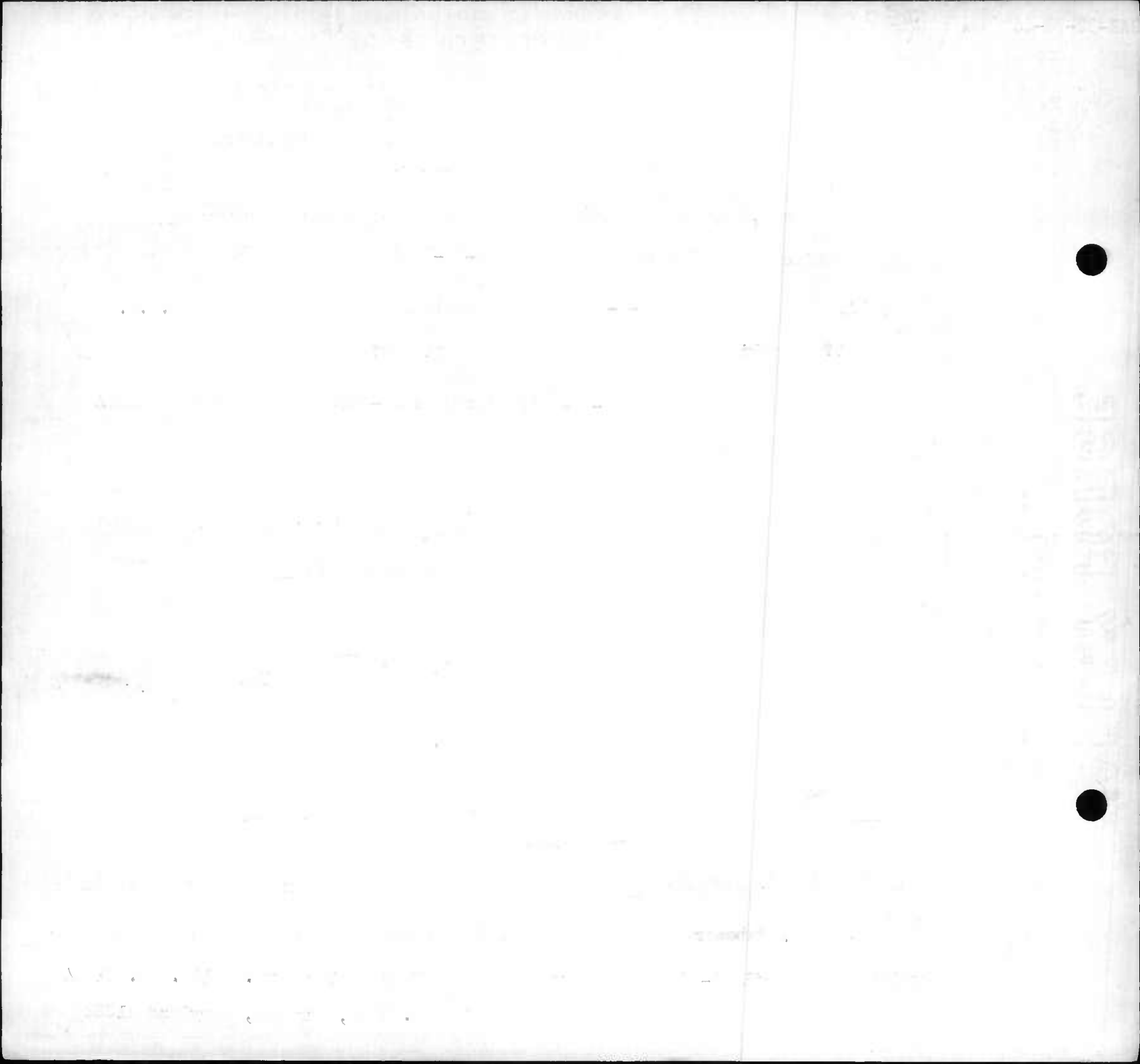
| M-230 66 04104 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04104 | |
|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 5. SEX | |
| Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland, #21224 | | Maryland
21-02
Baltimore
4940 Eastern Avenue, #21224 | | Female | |
| 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| White | | Married | | 2-13-1913 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) | |
| Button Hole operator Underwear Factory | | | | 53 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 11. BIRTHPLACE (State or foreign country) | |
| Frederick W. Franke | | Minnie Walte | | Maryland | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 212-10-5397 | | RECORDS: BCH, 4940 Eastern Ave., #21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) F.U.O. | | 1 month | |
| ANTECEDENT CAUSES | | (B) chr { acute pyelonephritis } > 1 month | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Heredo familial CNS disease 6 years | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | pneumonia, resolving
No septicemic fungal rxn | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 4/13/1966 to 4/20/1966, that (1) (we) last saw the deceased alive on 4/20/1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE | | 23B. DATE SIGNED | |
| | | James Sam Louie | | 4/20/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| JAMES SAM LOUIE | | BALT. CITY HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 4/25/66 | | Reston Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| APR 22 1966 | | Robert E. Jenkins, M.D. | | John J. Conner, Sr. Inc. 901. Nalline St. Balt. 23 Md. | |



FUNERAL DIRECTOR: IMPORTANT

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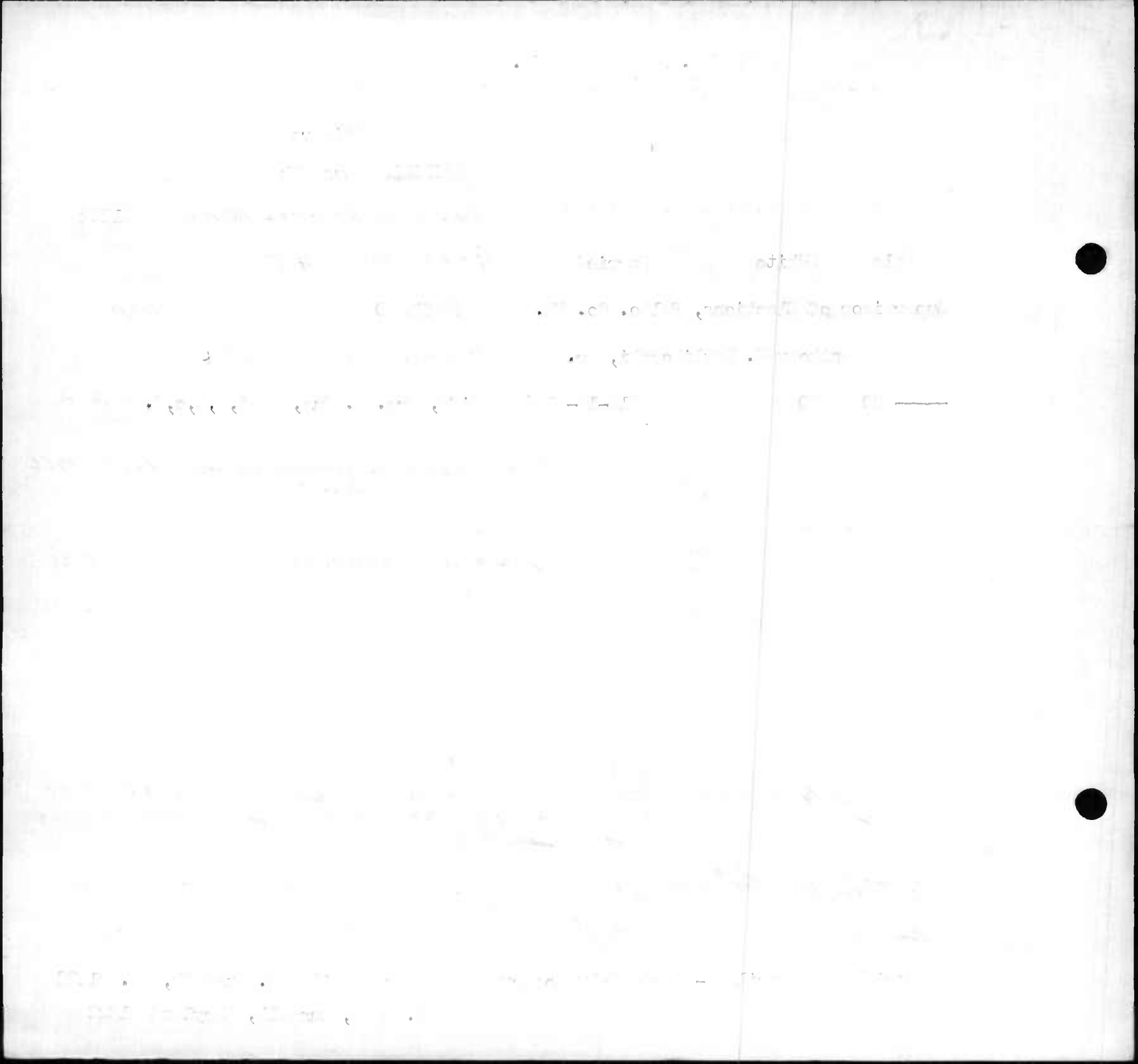
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04105 | |
|--|-------------------------|---|---|--|---|
| BIRTH NO. P-362 66 04105 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Sanne Peterson | | | 4-20-66 9:40 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | | A. STATE Maryland B. COUNTY Baltimore | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Dundalk | | |
| | | | D. STREET ADDRESS (If rural, give location)
8193 Delhaven Road 21222 | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
Widowed | 8. DATE OF BIRTH
1-20-1894 | 9. AGE (In years last birthday)
72 | 10. Under 1 Yr. Months Days
11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
- - | | 11. BIRTHPLACE (State or foreign country)
Finland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
?? Koski | | 14. MOTHER'S MAIDEN NAME
?? ?? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-24-3733 | | 17. INFORMANT ADDRESS
Records: BCH-4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| (A) CARDIAC ARREST | | | 2 MIN | | |
| (B) MYOCARDIAL INFARCTION | | | 3 DAY | | |
| (C) ARTERIOSCLEROSIS | | | - | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | | 21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 4-20-66 to 4-20-66 , that (1) me last saw the deceased alive on 4-20-66 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Joel F. Habener | | | | 23B. DATE SIGNED
4-20-66 | |
| 23C. PHYSICIAN'S NAME (Type)
Joel F. Habener | | | | 23D. ADDRESS
4940 Eastern Avenue, Baltimore, Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
April 23-1966 | | 24C. NAME OF CEMETERY or CREMATORY
Oak Lawn | |
| 24D. LOCATION
7225 Eastern Ave. Balto. Md. 21224 | | 25A. DATE REC'D BY HEALTH DEPT.
APR 22 1966 | | | |
| 25B. NAME OF REGISTRAR
John J. Duda | | 25C. FUNERAL DIRECTOR ADDRESS
JOHN J. DUDA, Dundalk, Maryland 21222 | | | |



FUNERAL DIRECTOR: IMPORTANT

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| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|------------------|--|-----------------------------|--|---|
| 66 04106 | | CERTIFICATE OF DEATH | | 66 04106 | |
| M.E. CASE NO. | | ANTHONY W. PAWLIKOWSKI JR. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | ANTHONY W. PAWLIKOWSKI, JR. | | 4 - 21 - 66 5 ¹⁰ A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE
M.D. Baltimore | | B. COUNTY | |
| 44 UNION MEMORIAL HOSP | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Dundalk 53-00 | |
| | | D. STREET ADDRESS (If rural, give location) | | 3407 CORNWALL ROAD 21222 | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
9-27-20 | 9. AGE (In years last birthday)
45 | 10. Under 1 Yr. Months Days
11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Supervisor of Elections, Balto. Co. Md. | | | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Anthony W. Pawlikowski, Sr. | | FRANCES SPINEK | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO NO | | 216-16-3126 | | Wife, Mrs. M. Sue, # 4, a, b, c, d. J. A. A. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 422114581.1 | | ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | 1957-1966 | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) LAMENILS CIRRHOSIS | | 19? -1966 | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | EPISTAXIS | | 4-15-66 ^{To} 4-21-66 | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (this hospital) attended the deceased from 4-15-1966 to 4-21-1966, that (I) last saw the deceased alive on 4-20-1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Arthur M. LaBunce Jr | | | | 23B. DATE SIGNED
4-21-66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| D.M.C. (Samuel J. Lloyd) | | | | UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | April 25-1966 | | Holy Rosary | |
| | | | | German Hill Rd. Dundalk, Md. 21222 | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| APR 22 1966 | | Robert E. Faldut | | JOHN J. DUDA, Dundalk, Maryland 21222 | |



FUNERAL DIRECTOR: IMPORTANT

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5-5001

66 04107

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

66 04107

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Bertha N. Swam

2. DATE AND HOUR OF DEATH

April 19/66

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

German Home, 22 S. Athol Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Ma.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Balto. 29

D. STREET ADDRESS (If rural, give location)

22 S. Athol Ave

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

6/19/90

9. AGE (In years
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Saleslady
x Saleslady, May Co.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Wm. H. Swam

14. MOTHER'S MAIDEN NAME

Sara h----

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

212 10 7725

17. INFORMANT

ADDRESS

A- Records, German Home, 22 S. Athol
AVE

18. 332 X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) Cerebral Vascular Thrombosis
DUE TO
(B) Arteriosclerosis, generalized
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At ☐ Not While
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 19 65 to April 19 66
that (I) (we) last saw the deceased alive on April 19 66 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

William J. Bryson M.D.

Attending
Phys.

Med.
Director

Staff
Phys.

23B. DATE SIGNED

20 April 66

23C. PHYSICIAN'S
NAME (Type)

William J. Bryson M.D.

23D. ADDRESS

4605 Edmondson Balto. 29

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/22/66

24C. NAME OF CEMETERY or CREMATORY

St. Mary's Cemetery

24D. LOCATION

Roland Ave. & 39th St
Balto. Md zone 11

25A. DATE REC'D BY HEALTH DEPT.

APR 22 1966

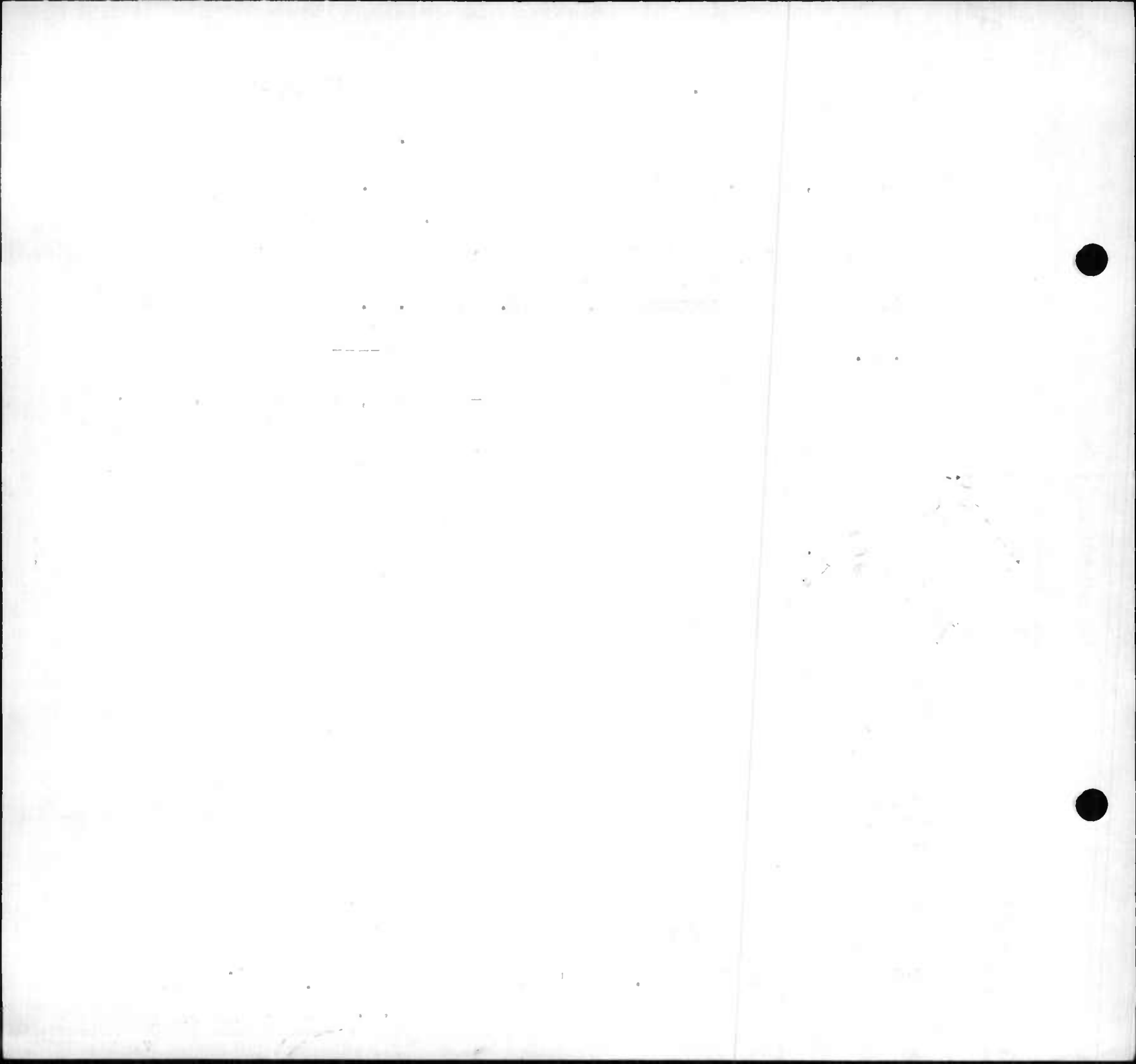
25B. NAME OF REGISTRAR

Robert E. Sank

25C. FUNERAL DIRECTOR

Witzke F.D. 4101 Edmondson A

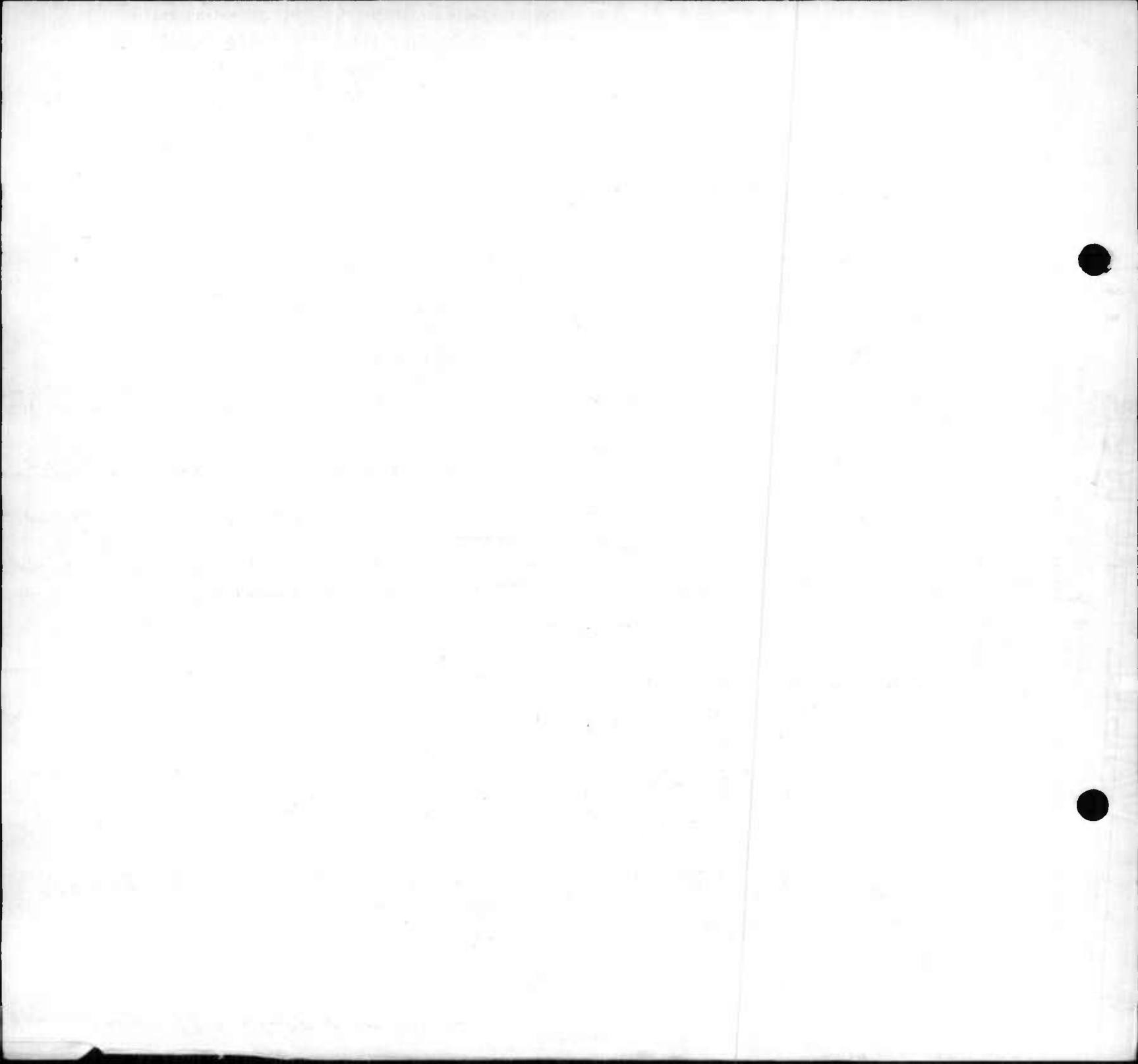
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

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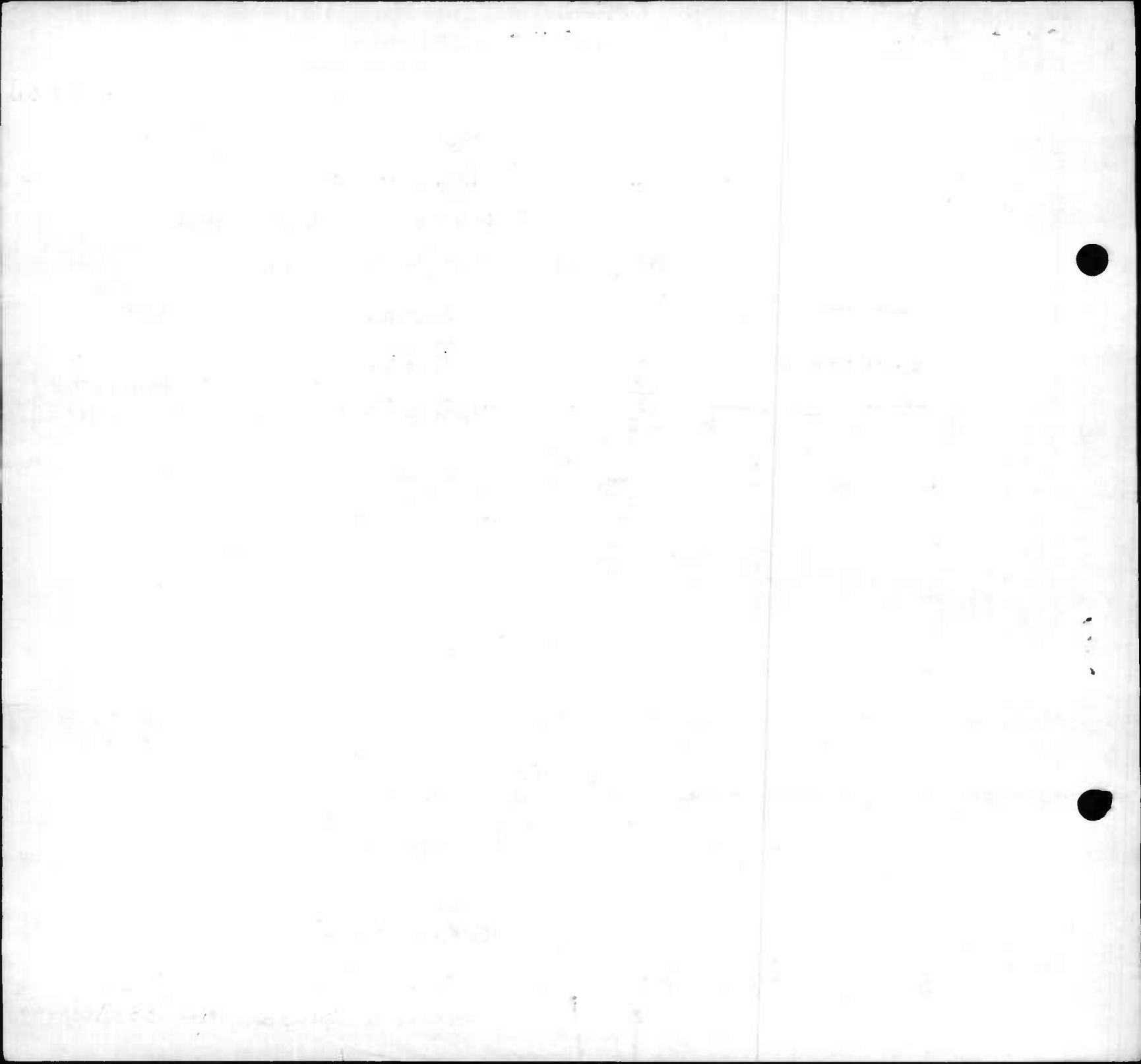
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|--|--|--|--|--|
| BIRTH NO.
66 04108 | | CERTIFICATE OF DEATH | | 66 04108 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | GROSS, SYDNEY ROBINSON | | 4/21/66 12:25 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE
B. COUNTY | | | |
| MONTEBELLO STATE HOSPITAL | | 1909 FRANKLIN ST
BALTIMORE 21223 | | | |
| 5. SEX
F | | 6. RACE
C | | 7. MARRIED, NEVER MARRIED
(WIDOWED) DIVORCED (specify) | |
| | | | | | |
| 8. DATE OF BIRTH
MARCH 7 '79 | | 9. AGE (In years last birthday)
86 | | 10. CITIZEN OF WHAT COUNTRY?
US | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Domestic | | Per Family | | Maryland | |
| 13. FATHER'S NAME
James Harold | | 14. MOTHER'S MAIDEN NAME
Cecelia Soller | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| | | | | 16. SOCIAL SECURITY NO. | |
| | | | | 17. INFORMANT
MRS Catherine Smith | |
| | | | | ADDRESS
1909 Franklin St. Balt. MD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | Generalized arteriosclerosis | | 4 mo | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Liver Dehydration | | 4 mo | |
| | | Left femoral neck fracture | | 4 mo | |
| | | Decubitus ulcer | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
1-5-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Good | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
yes | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
1909 Franklin St. | |
| 21D. TIME OF INJURY (APPROX.)
1-5-66 12:30 PM | | 21E. INJURY OCCURRED
While At <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Feet dizzy & fell on kitchen floor | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-17-1966 to 4-21-1966, that (I) (we) last saw the deceased alive on 4-21-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Young Lee Lee | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4-21-22 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
Montebello State Hosp. | | | |
| 24A. BURIAL OR CREMATION
Burial | | 24B. DATE
4/24/66 | | 24C. NAME OF CEMETERY OR CREMATORY
BROOK'S CHAPEL | |
| | | | | 24D. LOCATION (City, town, or county) (State)
CALVERT Co. MD | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 22 1966 | | 25B. NAME OF REGISTRAR
R. E. Fisher | | 25C. FUNERAL DIRECTOR
Mansueti & Sons 638 N. G. M. Rd | |
| | | | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--------------|--|-------------------------------|--|-------------------------------------|
| BIRTH NO.
66 04109 | | CITY HEALTH DEPT
BALTIMORE CITY | | Registered No.
62906
66 04109 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) REGINA SPINDELL | | | |
| 2. DATE AND HOUR OF DEATH
4-20-66 112 Noon | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
LEVINDALE Hebrew Home & Inf. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
GREENSPRING & BELV. AVE. | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOW | 8. DATE OF BIRTH
2/14/1922 | 9. AGE (In years last birthday)
94 | 10. CITIZEN OF WHAT COUNTRY?
USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Austria | |
| 13. FATHER'S NAME
LAWRENCE | | 14. MOTHER'S MAIDEN NAME
RUTH | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY No. | | 17. INFORMANT
SILVER SPRING, MD
MRS PAUL REZNEK 13921 MILLS AVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
E 902.1/260
Septicemia
Fracture, L femur
Pyelonephritis | | 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
ASCVD, Diabetes | | INTERVAL BETWEEN ONSET AND DEATH
4 days.
10 yrs. | |
| 19A. DATE OF OPERATION
3/12/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Fracture of Hip | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Intimacy | | 21C. WHERE DID INJURY OCCUR?
Levindale 27-17 | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
17 10 66 7 AM | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Fell from toilet | |
| 22. I certify that (I) (this hospital) attended the deceased from June 15, 1959 to April 20, 1966, that (I) (we) lost saw the deceased alive on April 20, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Lawrence Solomon | | | | 23B. DATE SIGNED
4-20-66 | |
| 23C. PHYSICIAN'S NAME (Type)
M.D. SINAI HOSPITAL | | | | 23D. ADDRESS
M.D. SINAI HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/21/66 | | 24C. NAME OF CEMETERY or CREMATORY
Roosevelt Memorial Park Phil, Pa | |
| 24D. LOCATION
(City, town, or county) (State)
Pa | | 25A. DATE REGD. BY HEALTH DEPT.
APR 22 1966 | | 25B. NAME OF REGISTRAR
Robert E. [illegible] | |
| 25C. FUNERAL DIRECTOR
SYLVAN S. LEVINSON, INC | | 25D. ADDRESS
3319 [illegible] Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|------------------|---|------------------------------------|--|---|--|--|--|--|
| 66 04110
CERTIFICATE OF DEATH | | | | | Registered No. 66 04110 | | | | |
| BIRTH NO.
M.E. CASE NO. | | | | | 2. DATE AND HOUR OF DEATH
4/20/66 11:20p M. | | | | |
| 1. NAME OF DECEASED
(Type or Print) GASON REICH | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
8. COUNTY 15-11 | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
42 SINGI HOSPITAL | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
3904 HILTON RD | | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
10/14/1904 | 9. AGE (In years last birthday)
61 | If Under 1 Tr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
BUTCHER | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
WYOMING PA | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
JACOB | | | 14. MOTHER'S MAIDEN NAME
HANNAH | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
Hospr Chart | | | ADDRESS | | | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH
(A) Acute Myocardial Infarction
DUE TO
(B) Atheroscl. Heart Disease
DUE TO
(C) none | | INTERVAL BETWEEN ONSET AND DEATH
Hours
chronic | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | none | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLINTING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1952 to 4/20 1966, that (I) (we) last saw the deceased alive on 4/20 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Louis V. Blum, M.D. | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/20/66 | | |
| 23C. PHYSICIAN'S NAME (Type)
Louis V. Blum, M.D. | | | | | 23D. ADDRESS
M.D. 3502 W. ROGER AVE BALTIMORE 21215 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/22/1966 | | 24C. NAME OF CEMETERY or CREMATORY
WEST PITTSBURG CEM. | | 24D. LOCATION (City, town, or county) (State)
WEST PITTSBURG PA | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 22 1966 | | 25B. NAME OF REGISTRAR
Robert E. Fisher | | 25C. FUNERAL DIRECTOR
SYLVAN S. LEWIS & SON | | ADDRESS
3319 CLYMPIA AVE | | | |

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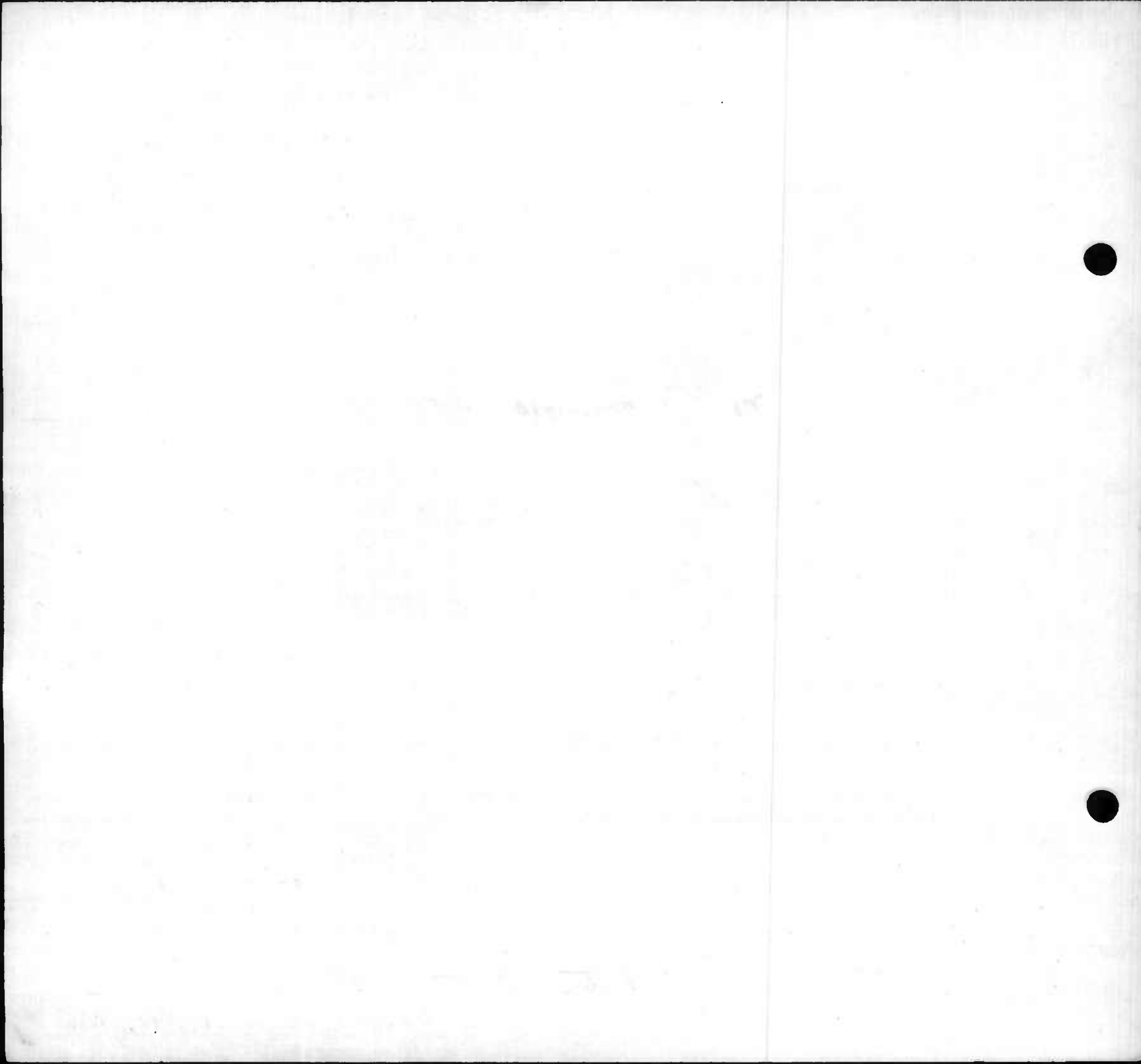
10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. | |
|--|---|--|--|--|---|--|---|
| BIRTH NO. 66 04111 | | | | | | | |
| M.E. CASE NO. | | | | 66 04111 | | | |
| 1. NAME OF DECEASED
(Type or Print) ANDERSON CLARENCE | | | | 2. DATE AND HOUR OF DEATH
APRIL 21, 1966 4:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
UNIVERSITY HOSPITAL | | (If not in hospital or institution, give street address or location) | | A. STATE
MD. BALTIMORE | | B. COUNTY | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | 18-01 | |
| | | | | D. STREET ADDRESS (If rural, give location)
905 W. LEXINGTON ST. | | | |
| 5. SEX
M | 6. RACE
C | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
APRIL 1899 | 9. AGE (In years last birthday)
67 | If Under 1 Yr.
Months: Days: | If Under 24 Hrs.
Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
NORTH CAROLINA. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. |
| 13. FATHER'S NAME
? | | | 14. MOTHER'S MAIDEN NAME
? | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
21701-5770 | | 17. INFORMANT ADDRESS
WIFE JANE | | |
| 18. 332X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) CEREBRAL EDEMA.
DUE TO
HEM. CEREBRAL INFARCTION
(B) HEMORRAGE
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
APRIL 17, 1966 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
TUMOR SUSPECT | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 17, 1966 to APRIL 21, 1966 , that (I) (we) lost saw the deceased alive on APRIL 21, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
R. Paul | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/21/66 | |
| 23C. PHYSICIAN'S NAME (Type)
RONALD L. PAUL | | | | 23D. ADDRESS
M.D. UNIVERSITY HOSPITAL, BALT., MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-25-66 | | 24C. NAME of CEMETERY or CREMATORY
Arbutus Court | | 24D. LOCATION (City, town, or county) (State)
Balto md | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 22 1966 | | 25B. NAME of REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR
E. O. Wilson | | ADDRESS
1000 Brantley Ave. | |



1
B-622

66 04112

BALTIMORE CITY HEALTH DEPARTMENT

66 04112

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

| | | | | | |
|--|-------------------------|---|--|---|---|
| 1. NAME OF DECEASED
(Type or Print) EMBRAY BURGESS | | | | 2. DATE AND HOUR PRONOUNCED DEAD
April 20, 1966 2:55 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 Lutheran Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY _____
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 15-47
D. STREET ADDRESS (If rural, give location)
3029 Windsor Avenue | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Married | 8. DATE OF BIRTH
March 17, 1900 | 9. AGE (In years last birthday)
66 | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Minister | | | 11. BIRTHPLACE (State or foreign country)
South Carolina | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME
Unknown | | | 14. MOTHER'S MAIDEN NAME
Elsie | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO.
248-10-1911 | 17. INFORMANT ADDRESS
Mrs. Leah Burgess 3029 Windsor Ave. | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>18. 422.1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease.</p> <p>ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> </div> <div style="width: 50%;"> <p>CAUSE OF DEATH</p> <p>(A) DUE TO _____</p> <p>(B) DUE TO _____</p> <p>(C) _____</p> </div> <div style="width: 5%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> | | | | | |
| <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| <p>22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type) | | Charles S. Petty, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
4/25/66 | | 23C. NAME of CEMETERY or CREMATORY
Carver Mem. Park | |
| 23D. LOCATION (City, town, or county) (State)
Prince George County, Md. | | | | | |
| 24A. DATE REC'D BY HEALTH DEPT.
APR 22 1966 | | 24B. NAME OF REGISTRAR
Robert E. [Signature] | | 24C. FUNERAL DIRECTOR ADDRESS
Wm C March 928 E. North Ave. | |

VALLEY FORMS

1945-1946

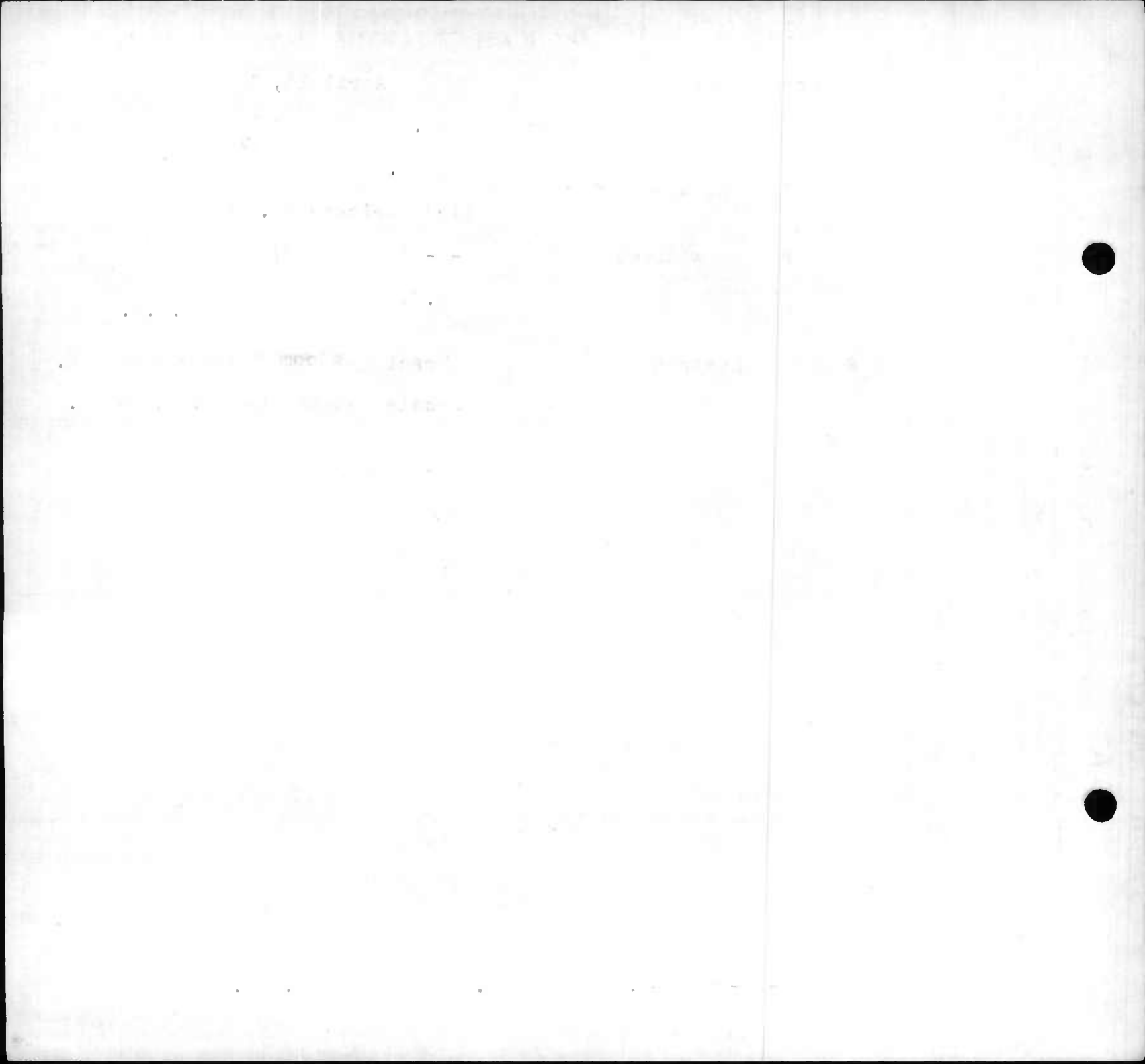
1945-1946

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 64113 | | |
|---|------------------|---|--|--|--|---------------------------------------|--|--|--|-----------------------------|--|--|
| BIRTH NO. 66 04113 | | | | | | | | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Anna Grant | | | | | 2. DATE AND HOUR OF DEATH
April 18, 1966 1:45 P. M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
90 Bar Will Bar Nursing Home | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 16-82
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Balto.
D. STREET ADDRESS (If rural, give location)
1159 Stricker St. | | | | | | | |
| 5. SEX
F | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
widowed | | | 8. DATE OF BIRTH
5-5-88 | 9. AGE (In years lost birthday)
77 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country)
S.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Sampson Chestnut | | | | | 14. MOTHER'S MAIDEN NAME
Gracie McCoom | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Bessie McNeal 1159 Stricker St. | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
1810 I
CAUSE OF DEATH
(A) Carcinoma of bladder
DUE TO
(B) DUE TO
(C) DUE TO
INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | |
| 19. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-2-1965 to 4-18-1966, that (I) (we) last saw the deceased alive on 4-17-1966 and that (in (my) (our) opinion) death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 23A. SIGNATURE
C.R. Campbell | | | | | | | | | | 23B. DATE SIGNED
4-21-66 | | |
| 23C. PHYSICIAN'S NAME (Type)
C.R. Campbell | | | | | 23D. ADDRESS
M.D. 1618 W. North Ave. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | | 24B. DATE
4-23-66 | | 24C. NAME of CEMETERY or CREMATORY
Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State)
Balto. Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 22 1966 | | | | | 25B. NAME OF REGISTRAR
R. E. E. E. | | 25C. FUNERAL DIRECTOR
George Selmon 1348 Calhoun St. | | | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH SAVAGE

2. DATE AND HOUR PRONOUNCED DEAD

April 19, 1966

3:10 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

708 W. Fairmount Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

708 W. Fairmount Ave.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
never married

8. DATE OF BIRTH

March 29, 1921

9. AGE (In years
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Edward Savage

14. MOTHER'S MAIDEN NAME

Amanda Diggs

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Amanda Johnson 905 Rosedale St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Gastro-intestinal hemorrhage
DUE TO cirrhosis of the liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?
yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-20-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4-23-66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

(City, town, or county)

Balto. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 22 1966

24B. NAME OF REGISTRAR

Robert E. Sisk

24C. FUNERAL DIRECTOR

George Nelson

ADDRESS

1348 Calhoun St

STANDARD FORM NO. 64

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C. 20250

MEMORANDUM FOR THE DIRECTOR

FROM: SAC, ALBUQUERQUE

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

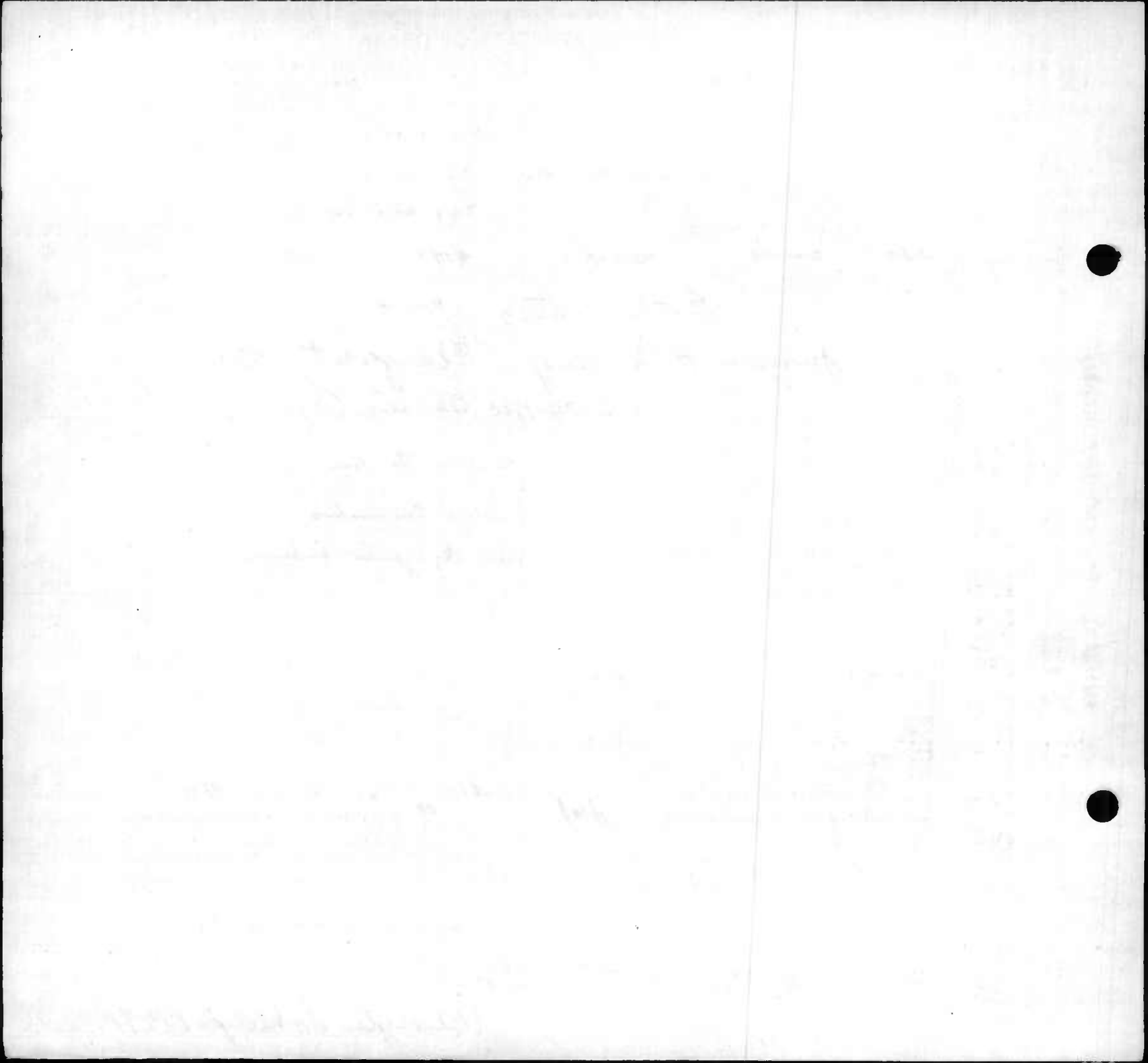
Very truly yours,
[Illegible Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. <u>66 04115</u> | |
|--|---------------------------|--|---|--|---|--|---------------------------------------|---|--|--------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| BIRTH NO. <u>66 04115</u> | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>RONALD A CONVEY Sr.</u> | | | | | 2. DATE AND HOUR OF DEATH
<u>APRIL 19, 1966</u> <u>9:00 P</u> M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
<u>LUTHERAN HOSPITAL OF MARYLAND</u>
<u>46</u> | | | | | A. STATE
<u>MARYLAND</u> | | | | | | |
| | | | | | B. COUNTY
<u>15-06</u> | | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
<u>3212 Velebrook Avenue</u> | | | | | | |
| 5. SEX
<u>MALE</u> | 6. RACE
<u>COLORED</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | | | 8. DATE OF BIRTH
<u>4/11/37</u> | 9. AGE (In years last birthday)
<u>29</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Bethlehem Steels</u> | | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | |
| 13. FATHER'S NAME
<u>James A Convey</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Margaret Brown</u> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO.
<u>212-34-1700</u> | | 17. INFORMANT
<u>Gloria Convey</u> | | | ADDRESS
<u>Same</u> | |
| 18. <u>204.1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

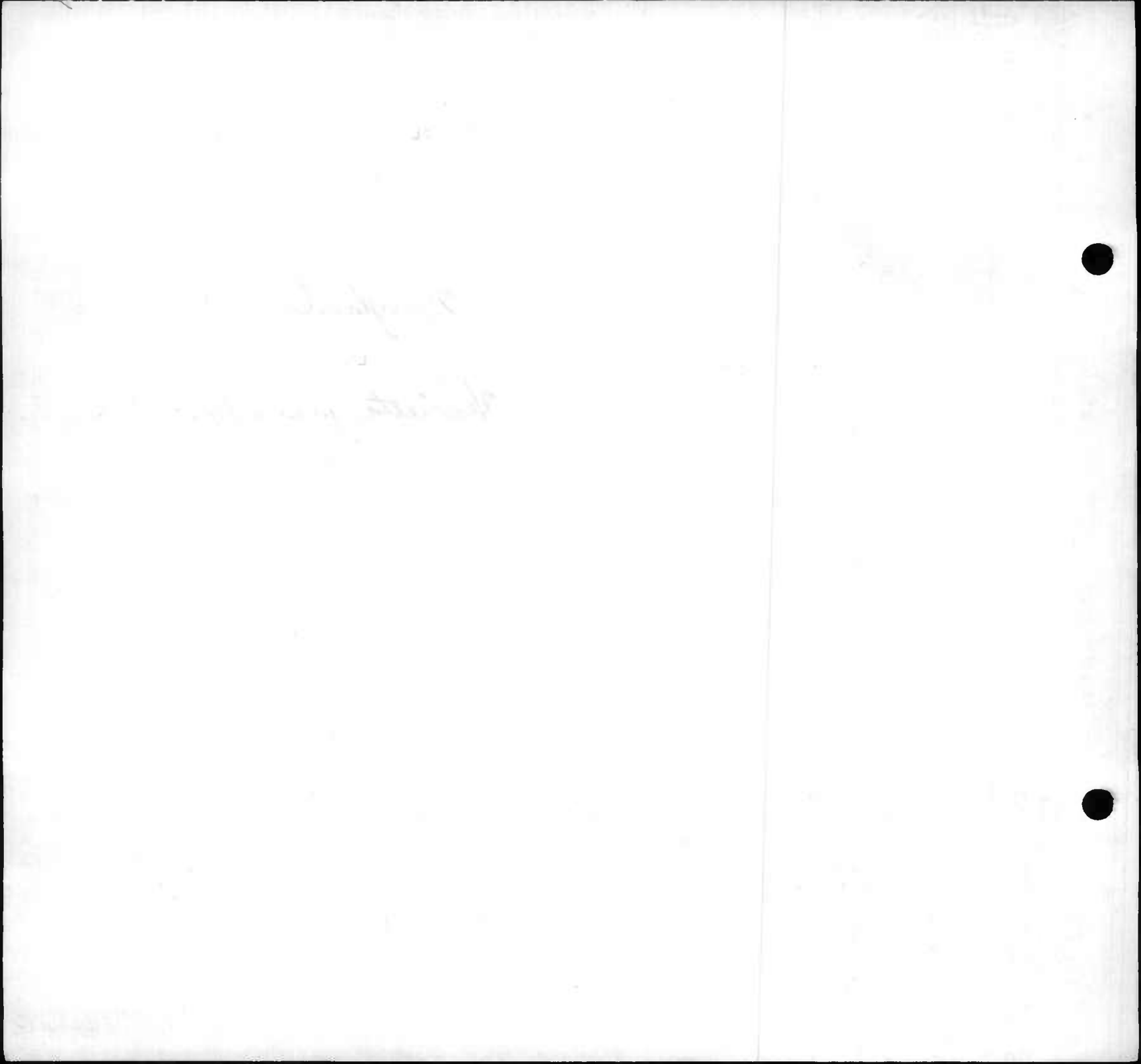
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH
(A) <u>Partial rhabdomyosarcoma</u>
DUE TO
(B) <u>Generalized Carcinomatosis</u>
DUE TO
(C) <u>Chronic Myelogenous Leukemia</u> | | | | | | |
| MEDICAL CERTIFICATION
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| | | | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>4/19/66</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>intestinal obstruction</u> | | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/11</u> 19 <u>66</u> to <u>4/19</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/19</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
<u>Desiderio L. Hebron, Jr.</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
<u>4/19/66</u> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>DESIDERIO L. HEBRON, JR.</u> | | | | | 23D. ADDRESS
<u>Lethron Hospital of Maryland</u> | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 24B. DATE
<u>4/25/66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Baltimore National</u> | | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore MD.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 22 1966</u> | | | 25B. NAME OF REGISTRAR
<u>Robert E. ...</u> | | | 25C. FUNERAL DIRECTOR
<u>Ullington S. Phillips</u> | | | ADDRESS
<u>1727 N. Mount St.</u> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04116 | |
|---|------------------|--|---|---|--|
| BIRTH NO. 66 04116 | | CERTIFICATE OF DEATH | | DATE AND HOUR OF DEATH 4/16/66 5:20 P.M. | |
| 1. NAME OF DECEASED (Type or Print) <i>Thomas, Charles</i> | | | 2. DATE AND HOUR OF DEATH | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>33 Tobas Hoptical Hosp</i> | | | A. STATE MARYLAND
B. COUNTY 14-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i>
D. STREET ADDRESS (If rural, give location)
<i>556 Bloom St</i> | | |
| 5. SEX <i>m</i> | 6. RACE <i>C</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <i>1/56/60</i> | 9. AGE (In years last birthday) <i>26</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME
<i>NATHAN THOMAS</i> | | | 14. MOTHER'S MAIDEN NAME
<i>ROSE HOLLAND</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
<i>Henrietta Jones</i> | | ADDRESS
<i>1445 N. Carey St</i> |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>465X-163X</i> | | | CAUSE OF DEATH
(A) <i>Coronary arrest</i>
(B) <i>Pericardial embolus</i>
(C) | | INTERVAL BETWEEN ONSET AND DEATH
<i>mins</i>
<i>mins</i> |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that <i>4/14</i> (this hospital) attended the deceased from <i>4/14</i> to <i>4/16</i> 19 <i>66</i> that <i>4/16</i> (we) last saw the deceased alive on <i>4/16</i> 19 <i>66</i> and that in <i>4/16</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>4/16</i> (We) (did) (did not) view the body after death. | | | 23B. DATE SIGNED <i>4/16/66</i> | | |
| 23A. SIGNATURE
<i>W.H. Spencer III</i> | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23C. PHYSICIAN'S NAME (Type)
<i>W.H. SPENCER III</i> |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | 24B. DATE
<i>4/20/66</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Mt. Auburn</i> |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>APR 22 1966</i> | | | 25B. NAME OF REGISTRAR
<i>Robert E. Jenkins</i> | | 25C. FUNERAL DIRECTOR
<i>Arlington S. Phillips</i> |
| 24D. LOCATION (City, town, or county)
<i>Baltimore</i> | | | 24E. ADDRESS (State)
<i>MD.</i> | | |
| 25D. ADDRESS
<i>1727 N. Monroe St.</i> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|---|---|--|
| BIRTH NO.
M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print)
Walter Johnson | | 2. DATE AND HOUR OF DEATH
April 17, 1966 2:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital
1514 Division Street
Baltimore, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 15-13
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
4221 Towanda Avenue | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
1-29-16 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Janitor | | 10B. KIND OF BUSINESS OR INDUSTRY
Calvert Distillery | 9. AGE (In years last birthday)
50 |
| 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Unknown William Johnson | | 14. MOTHER'S MAIDEN NAME
Unknown Emma Herley | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
228-07-2458 | 17. INFORMANT
Regina Johnson |
| 18. 420.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ARTERIOSCLEROTIC Heart Disease | | INTERVAL BETWEEN ONSET AND DEATH
Same | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pulmonary Embolism, Congestive Failure | | | |
| 19A. DATE OF OPERATION
no | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
no | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from March 18, 1966 to April 17, 1966 , that (I) (we) last saw the deceased alive on April 17, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Gilbert Banfield | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | 23B. DATE SIGNED
April 18, 1966 |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Gilbert Banfield | | 23D. ADDRESS
1514 Division Street BALTIMORE MD | |
| 24A. BURIAL CREMATION REMOVAL (Specify)
Burial | 24B. DATE
4/21/66 | 24C. NAME of CEMETERY or CREMATORY
Arbutus Mem. Ch. Baltimore | 24D. LOCATION (City, town, or county) (State)
MD |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 22 1966 Robert E. Taylor, MD | | 25B. NAME OF REGISTRAR
Wilmington Phillips | |
| 25C. FUNERAL DIRECTOR
1727 N. Mount St. | | ADDRESS | |

1214 Division Street
Baltimore, Maryland
1214 Division Street
Baltimore, Maryland
4521 Towanda Avenue
Baltimore, Maryland

Male Negro Married 1-29-16 20

Janitor Calvert Distillery Virginia 11.8.11

Unknown Unknown 528-07-5458 Regina Johnson 8.2.11

Handwritten signature

no

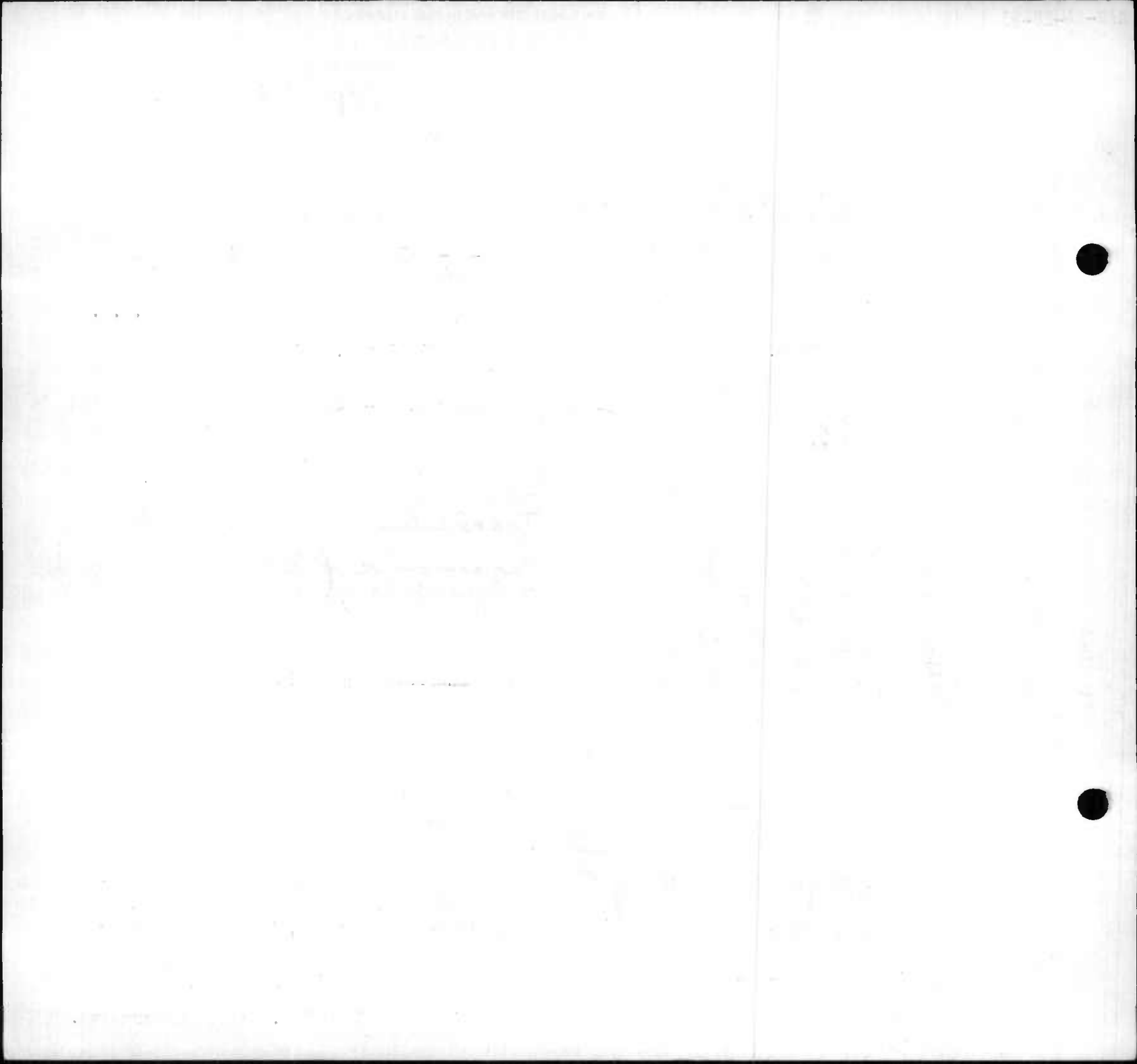
April 17, 66 March 18, 66 April 17, 66

Dr. Gilbert Hanfield 1214 Division Street

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|---|--|--|--|
| 5-530 66 04118 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04118 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Tillie Sommer</u> | |
| 2. DATE AND HOUR OF DEATH
<u>April 20, 1966</u> <u>7:00 a.m.</u> | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Baltimore City Hospitals</u>
<u>4940 Eastern Avenue</u>
<u>Baltimore, Maryland 21224</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY <u>26-11</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | |
| D. STREET ADDRESS (If rural, give location)
<u>3233 Fleet Street</u> <u>21224</u> | | 5. SEX <u>Female</u> 6. RACE <u>White</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u> | | | |
| 8. DATE OF BIRTH <u>3-14-1883</u> 9. AGE (In years last birthday) <u>83</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Germany</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>John H. VonSpreckelsen</u> | | 14. MOTHER'S MAIDEN NAME
<u>Christina R. Beicker</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>213-50-6037</u> | | 17. INFORMANT ADDRESS
<u>Records: BCH-4940 Eastern Avenue 21224</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
<u>Impaired secretions in trachea</u>
<u>Tracheitis</u>
<u>Carcinoma of larynx & hypopharynx</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
<u>30 minutes</u>
<u>2 days</u>
<u>? 1 & 2 yrs</u> | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
<u>April 12, 1966</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Carcinoma of larynx</u> | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>YES</u> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.)
Month Day Year Hour
<u>April 12 1966</u> | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>March 18</u> <u>1966</u> to <u>April 20</u> <u>1966</u> , that (I) (we) lost saw the deceased alive on <u>April 20</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Stephen Gregg</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>April 20, 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Stephen Gregg</u> | | 23D. ADDRESS
M.D. <u>4940 Eastern Avenue, Baltimore, Maryland</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4-23-1966</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Sacred Heart</u> | |
| 24D. LOCATION
<u>Baltimore County, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 22 1966</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Sisk, M.D.</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>Lilly & Zeiler Inc. 1901 Eastern Ave.</u> | | | |

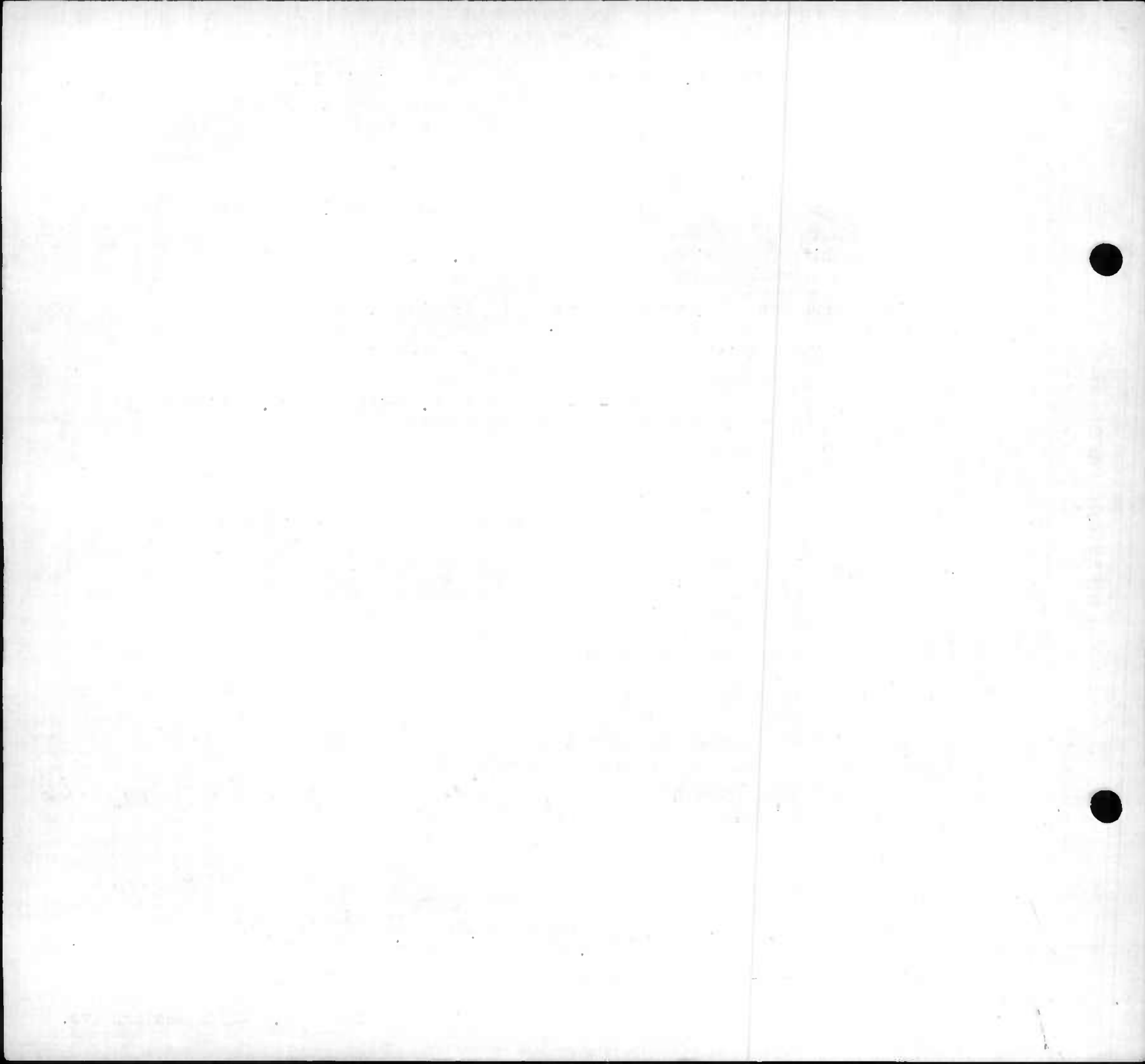


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 04119 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04119 | |
|--|------------------|---|------------------------------------|--|-------------------------------|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) JOHN H. SMITH | | | | 2. DATE AND HOUR OF DEATH
April 21, 1966 | | 2 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

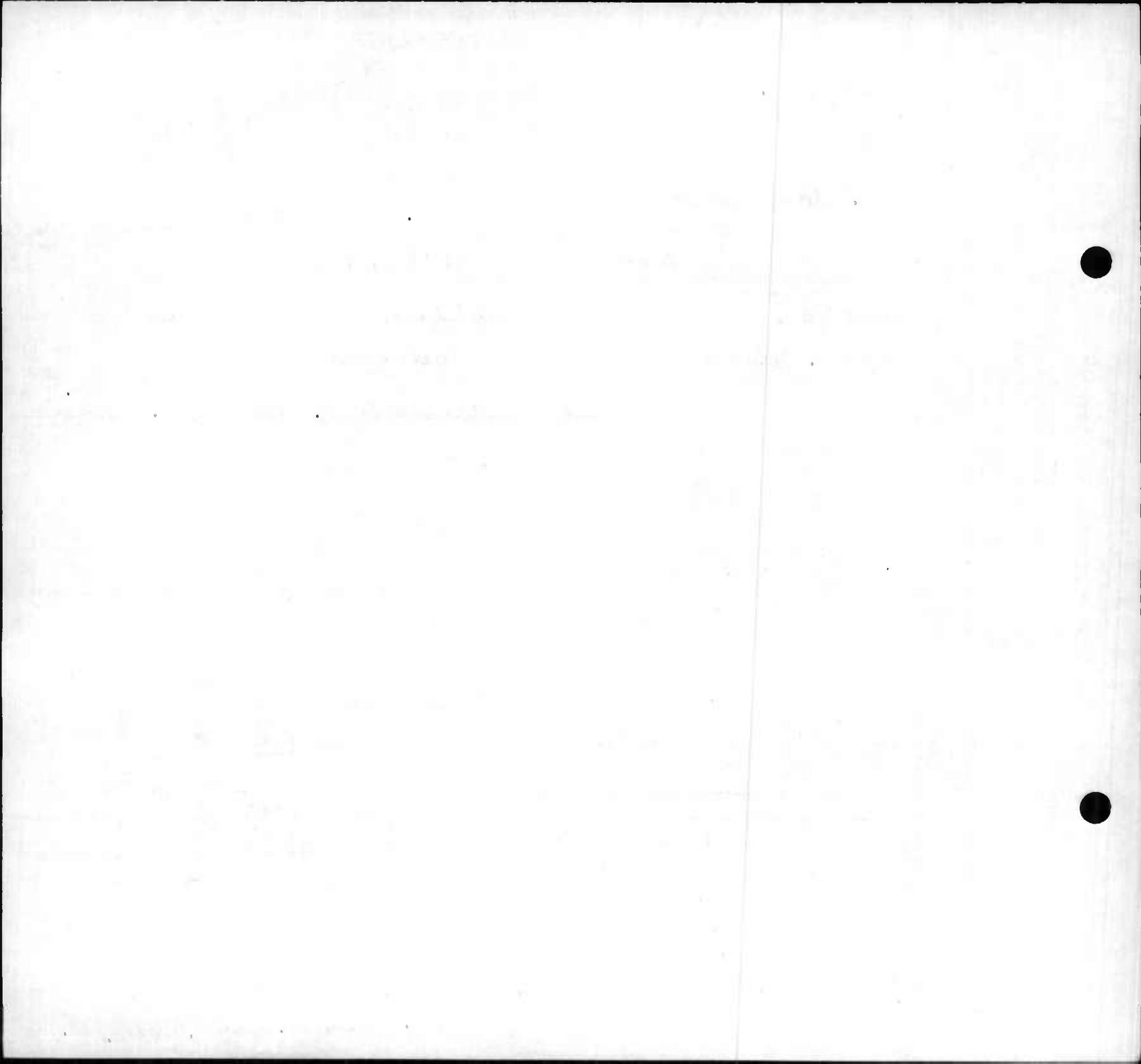
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
2214 Cambridge Street | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 1-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2214 Cambridge Street | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widower | 8. DATE OF BIRTH
Sept. 16, 1886 | 9. AGE (In years last birthday)
79 | If Under 1 Yr.
Months Days | If Under 24 Hrs.
Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Bargeman | | 10B. KIND OF BUSINESS OR INDUSTRY
Western Maryland R R | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Frank Smith | | | | 14. MOTHER'S MAIDEN NAME
Augusta Thiel | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
705-10-6535 | | 17. INFORMANT
John C. Smith | | ADDRESS
512 S. Lehigh Street | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) <i>Acute Coronary Thrombosis</i>
DUE TO <i>Arterio-sclerotic Heart</i>
(B) <i>chronic Ch. Emphysema</i>
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
<i>acute</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>April 19 64</i> to <i>April 21, 19 66</i> , that (I) (we) lost saw the deceased alive on <i>April 20 19 66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Israel J. Feinglus</i> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>4/22/66</i> | |
| 23C. PHYSICIAN'S NAME (Type)
ISRAEL J. FEINGLUS M.D. | | | | 23D. ADDRESS
7000 E. Pratt St | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-23-1966 | | 24C. NAME of CEMETERY or CREMATORY
Schwartz | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 22 1966 | | | | 25B. NAME OF REGISTRAR
<i>Robert E. Schreyer</i> | | 25C. FUNERAL DIRECTOR
Lilly & Zeiler Inc. | |
| | | | | | | ADDRESS
1901 Eastern Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

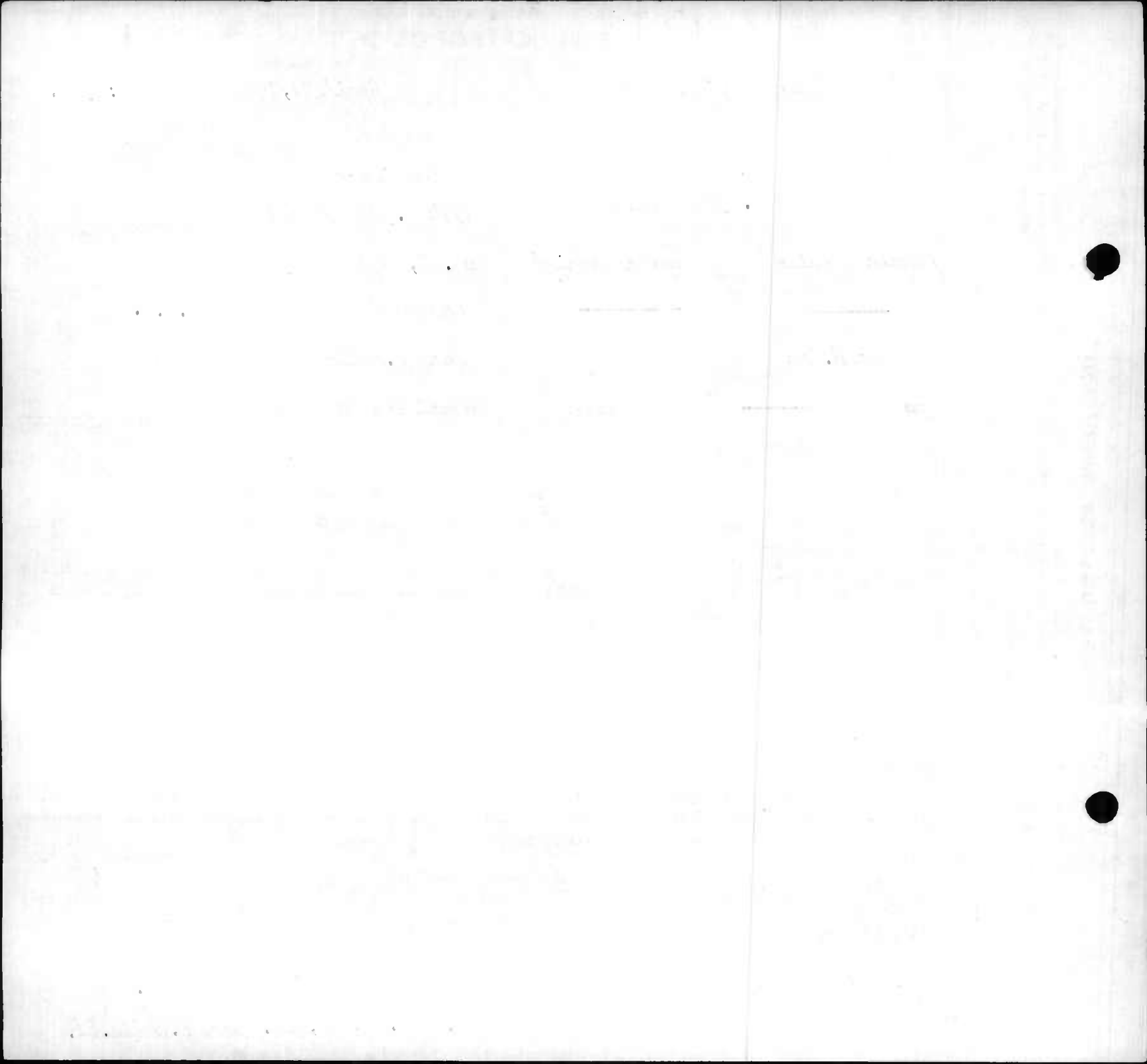
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|--|---|---|--|---|--|--|--|
| BIRTH NO. 66 04120 | | | | | CERTIFICATE OF DEATH | | | | |
| Registered No. 66 04120 | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Isabelle C. Black</i> | | | | | 2. DATE AND HOUR OF DEATH
<i>4/19/1966</i> <i>12³⁰ P.</i> M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>473 N. Linwood Avenue</i> | | | | | A. STATE <i>Maryland</i>
B. COUNTY <i>6-81</i> | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
<i>473 N. Linwood Avenue</i> | | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Widowed</i> | | 8. DATE OF BIRTH
<i>April 17, 1882</i> <i>84</i> | 9. AGE (In years last birthday) | If Under 1 Yr.
Months Days | If Under 24 Hrs.
Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore, Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>Joseph A. McDonald</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Dora Verges</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | | 16. SOCIAL SECURITY NO.
<i>None</i> | | 17. INFORMANT
<i>Miss Dorothy E. Scharf</i> | | ADDRESS
<i>473 N. Linwood Ave.</i> | |
| 18. <i>420.1 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) DUE TO <i>Coronary Artery Occlusion</i>
(B) DUE TO <i>Arterio-Sclerotic Cardis - Vascular</i>
(C) <i>Arteriosclerosis</i> | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>1 day</i>
<i>Unknown</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>3/4</i> <i>1966</i> to <i>4/19</i> <i>1966</i> , that (I) (we) last saw the deceased alive on <i>April 16</i> <i>1966</i> and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<i>Philibert Artigiani</i> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>4/20/66</i> | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Philibert Artigiani</i> | | | | | 23D. ADDRESS
M.D. <i>2305 Mayfield Ave. Baltimore, Md.</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>4/22/66</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>New Cathedral Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Maryland</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>APR 22 1966</i> | | | 25B. NAME OF REGISTRAR
<i>Robert E. Seibert, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>John A. Moran, Inc. 3000 E. Balto. St.</i> | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 0412 | |
|--|--------------|---|----------------------|--|--|
| 66 0412 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | <i>Mary Edith Lee</i> | | <i>April 21, 1966</i> <i>7:45 A.</i> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | B. COUNTY | |
| <i>1714 E. 30th Street</i> | | <i>Maryland</i> | | <i>9-86</i> | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | <i>Baltimore</i> | |
| | | D. STREET ADDRESS (If rural, give location) | | <i>1714 E. 30th Street</i> | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| <i>Female</i> | <i>White</i> | <i>never married</i> | <i>Aug. 27, 1882</i> | <i>83</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | <i>Maryland</i> | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| <i>John A. Lee</i> | | <i>Mary E. Rodley</i> | | <i>U.S.A.</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| <i>no</i> | | <i>none</i> | | <i>Robert Lee Matthews</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) <i>Arteriosclerotic C-V disease</i>
DUE TO
<i>Cerebral arteriosclerosis</i>
(B) <i>Generalized arteriosclerosis</i>
DUE TO
(C) | | <i>10 yrs.</i>
<i>10 yrs.</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 19 53</i> to <i>April 21 66</i> and that (I) (we) last saw the deceased alive on <i>April 19 66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>W. H. Grenzer</i> | | | | 23B. DATE SIGNED
<i>4.21.66</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>W. H. GRENZER</i> | | | | 23D. ADDRESS
<i>1520 E. 33rd St.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| <i>Burial</i> | | <i>4/23/66</i> | | <i>Oak Lawn Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| <i>Baltimore Md.</i> | | | | <i>John A. Moran, Inc.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| <i>APR 22 1966</i> | | <i>John A. Moran, Inc.</i> | | <i>3000 E. Balto. St.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|---|---------------------------|---|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| BIRTH NO.
66 04122 | | Registered No. 66 04122 | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) BROOKS, HORACE | | | | | | 2. DATE AND HOUR OF DEATH
4/17/66 4:45 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
90
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Lincoln Memorial Nursing Home
27 N. Carey St. Balto. Md | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MD. B. COUNTY Caroline
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 55-00
D. STREET ADDRESS (If rural, give location) P.O. Box 365. Ridgely Md. | | | | | |
| 5. SEX
Male | 6. RACE
Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Never Married | | 8. DATE OF BIRTH
Dec. 3, 1902 | 9. AGE (In years last birthday)
64 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Sidney Brooks | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth Cooper (deceased) | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
Lincoln Memorial Home
ADDRESS 27 N Carey St | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
PNEUMONIA | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 DAYS | | | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
MALNUTRITION, DEHYDRATION AND DECUBITI (CHRONIC) | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At <input type="checkbox"/> Work Not White At <input type="checkbox"/> Work | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/11/61 19 to 4/17/66 19, that (I) (we) last saw the deceased alive on 4/17/66 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Hollis Seunarine, M.D. | | | | | | 23B. DATE SIGNED
4/18/66 | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
HOLLIS SEUNARINE | | | | | | 23D. ADDRESS
5519 KENNISON AVENUE | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4-21-66 | | 24C. NAME OF CEMETERY or CREMATORY
Williamsburg Cem | | 24D. LOCATION (City, town, or county) (State)
EASTON Rt. 2. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 22 1966 | | 25B. NAME OF REGISTRAR
R. G. E. Feltman | | 25C. FUNERAL DIRECTOR
James R. Dabnick | | | | ADDRESS
Easton, Md. | | | |

1/1/19

1/1/19

1/1/19

1/1/19

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FUNERAL DIRECTOR: IMPORTANT

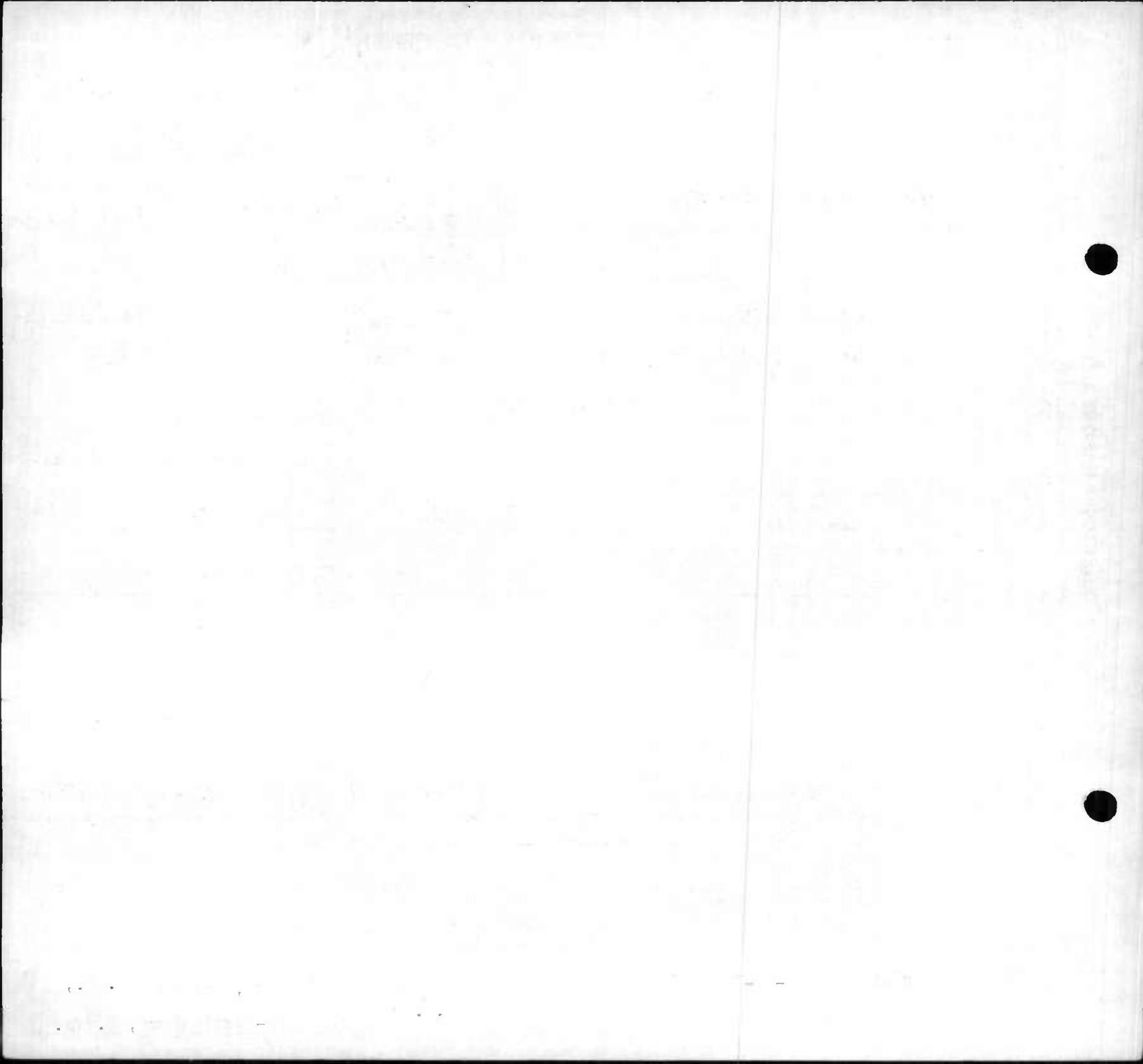
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered | |
|--|---------------------|---|------------------------------------|--|---|
| 66 04123 | | | | 66 04123 | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) CRAIG, ANNA | | 2. DATE AND HOUR OF DEATH
4/20/66 - 12⁴³ P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
North Charles Gen. Hosp.
49 2724 N. Charles ST. | | A. STATE Md. 8. COUNTY 26-02 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location)
5204 Babra Ave. Barbara | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
12-6-80 | 9. AGE (In years last birthday)
85 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland - U.S.A. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
Nutzler, Andeev | | 14. MOTHER'S MAIDEN NAME
M. VALENTINE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 443X1 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) C.V.A. Intracerebral Hemorrhage | | | |
| ANTECEDENT CAUSES | | (B) Left Hemisphere and cerebellum left | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Hypertensive heart disease | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) this hospital attended the deceased from 4/16 19 66 to 4-20 19 66 , that (I) was last saw the deceased alive on 4-20 19 66 and that in (my) your opinion death occurred on the date and hour and from the causes stated above. (I) we (did) did not view the body after death. | | | | | |
| 23A. SIGNATURE
[Signature] | | | | 23B. DATE SIGNED
4/20/66 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. HINNO | | | | 23D. ADDRESS
M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/25/66 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Carmel Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 22 1966 | | 25B. NAME OF REGISTRAR
Robert E. [Signature] | | 25C. FUNERAL DIRECTOR
John A. Moran, Inc. | |
| | | | | ADDRESS | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

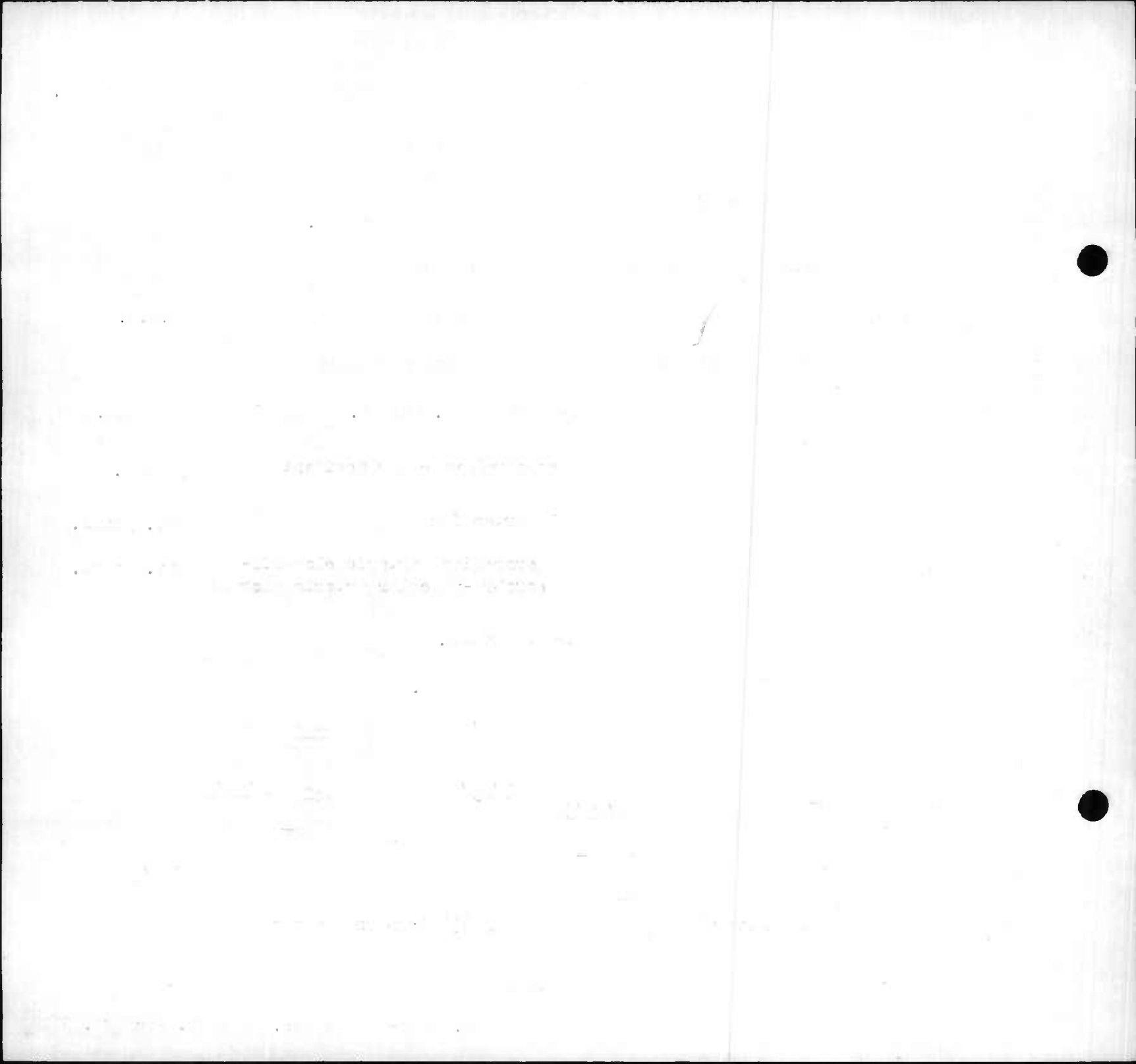
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|---------|--|---|--|--|
| 66 04124 | | CERTIFICATE OF DEATH | | 66 04124 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | Ruth JACOPETTI | | 4/20/66 12:19 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| MARYLAND GENERAL HOSPITAL | | MD HAYFORD | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | JOPPA 62-00 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 1413 ALEXIS DRIVE | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| F | W | M | 3/14/99 | 67 | HOUSEWIFE |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| | | | W. VA | | US |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| DAVID DeUNGER | | | RITA Stamey DeUNGER | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| NO | | | 572-10-5252 | | Chart |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES | | | CHRONIC RENAL FAILURE 6 mo. | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CHRONIC PYELONEPHRITIS yrs. | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| NONE | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| NO | | NO | | NO | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| NO | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | NO | |
| 22. I certify that (X) (this hospital) attended the deceased from 3/26/66 to 4/20 19 66, that (X) (we) last saw the deceased alive on 4/20 66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| J. W. MAUN | | | | 4/20/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| J. W. MAUN | | | | MD. GENERAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 4-23-1966 | | Pleasant View Memory Gardens | |
| | | 24D. LOCATION | | (City, town, or county) (State) | |
| | | Martinsburg, Berkeley W. Va., | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| APR 22 1966 | | Robert E. Sullivan | | H.K. Brown | |
| | | | | Brown Funeral Home-Martinsburg, W. Va. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

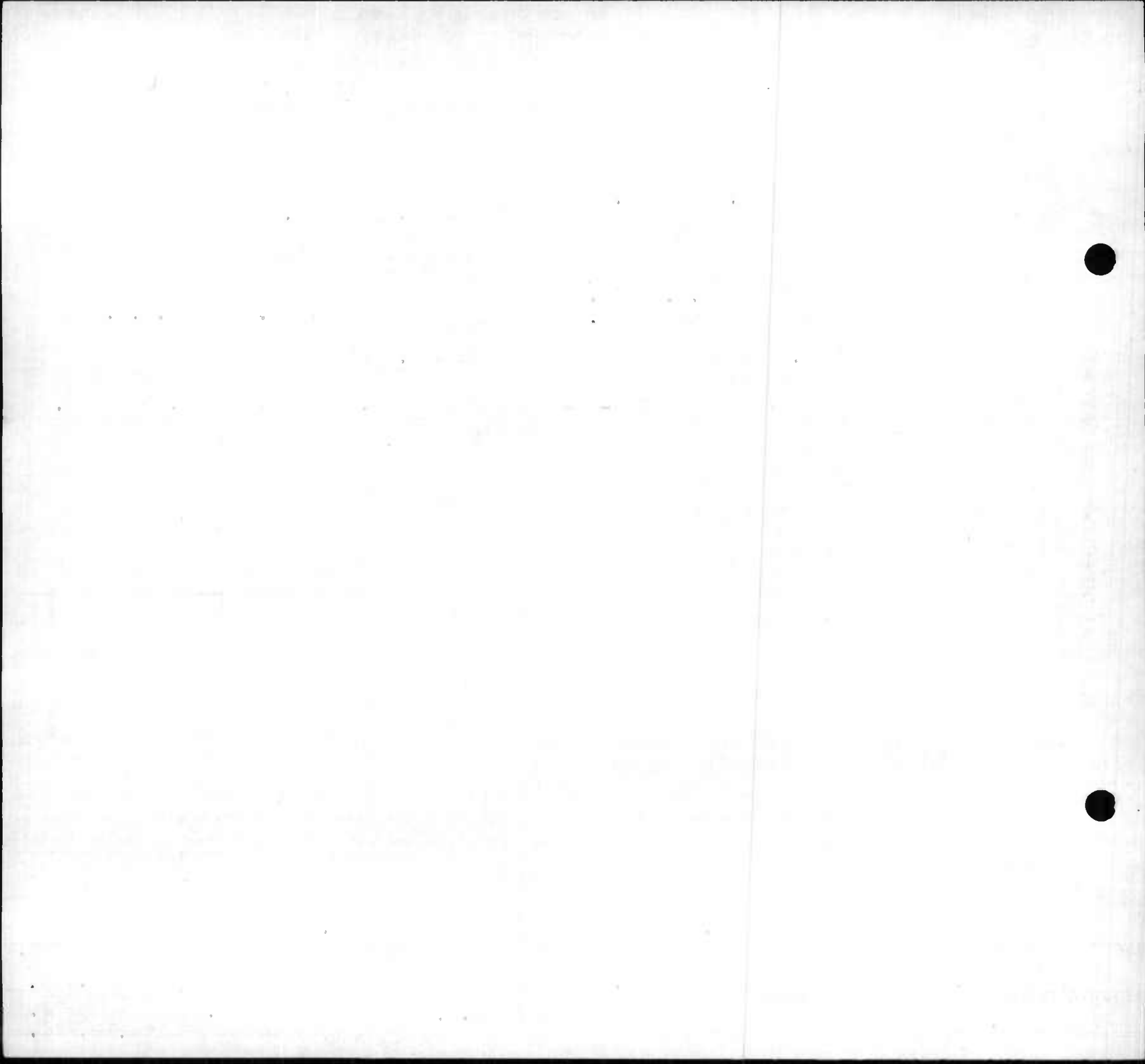
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 04125</u> | |
|--|----------------------|--|---|---|--|
| BIRTH NO. <u>66 04125</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH <u>4/22/66</u> <u>4</u> A. M. | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Lottie Virginia Wilson</u> | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>2623 Barclay Street</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY <u>12-03</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>
D. STREET ADDRESS (If rural, give location) <u>2623 Barclay St.</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>July 4, 1876</u> | 9. AGE (In years last birthday) <u>89</u> | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Thomas Merchant</u> | | 14. MOTHER'S MAIDEN NAME <u>Rachel Connley</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>212-10-3042D</u> | 17. INFORMANT <u>Mrs. Ruth L. Bowers 2623 Barclay St. #18</u> ADDRESS | | |
| 18. <u>931 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
<u>cerebral vascular accident</u>
(A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days.</u> | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>hypertension</u> DUE TO | | sev. years. | |
| | | (C) <u>generalized arteriosclerosis-cerebro-vascular arteriosclerosis</u> | | sev. years. | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Chronic Nephritis.</u> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO.</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>4/25/1962</u> to <u>4/22/66</u> 19 <u>62</u> to <u>4/22/66</u> 19 <u>62</u> and that <u>(1)</u> (we) lost saw the deceased alive on <u>4/21/66</u> 19 <u>62</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(1)</u> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>E. Ellsworth Cook</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED <u>4/22/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>E. Ellsworth Cook</u> | | 23D. ADDRESS <u>2431 Maryland Avenue</u> M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>4/25/66</u> | 24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>APR 22 1966</u> | | 25B. NAME OF REGISTRAR <u>E. Ellsworth Cook</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202</u> | |



FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04126 | |
|---|---------------------|--|--------------------------------------|---|---|
| BIRTH NO. 66 04126 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Eva Harman Abel | | 2. DATE AND HOUR OF DEATH
April 20, 1966 15:45 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 9-03 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
619 E. 34th St. | | D. STREET ADDRESS (If rural, give location)
619 E. 34th St. | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
9/17/1893 | 9. AGE (In years last birthday)
72 | 10. Under 1 Yr. Months Days
11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. Navy Dept. | | 11. BIRTHPLACE (State or foreign country)
Hagerstown, Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Frederick D. Harman | | 14. MOTHER'S MAIDEN NAME
Emma C. Valentine | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
214-09-9805 | | 17. INFORMANT ADDRESS
Maurice S. Harman, 615 E. 34th St. | |
| 18. 42011 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
Coronary Occlusion | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/19 19 66 to 4/20 19 66 , that (I) (we) last saw the deceased alive on 4/19 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Joseph R. Liberto | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/22/66 | |
| 23C. PHYSICIAN'S NAME (Type)
Joseph R. Liberto | | 23D. ADDRESS
M.D. 3508 Bank St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/23/1966 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Tabor | |
| 24D. LOCATION (City, town, or county) (State)
Rocky Ridge, Frederick Co., Md. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 22 1966 | | 25B. NAME OF REGISTRAR
R. E. Jenkins | |
| 25C. FUNERAL DIRECTOR ADDRESS
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | | | |

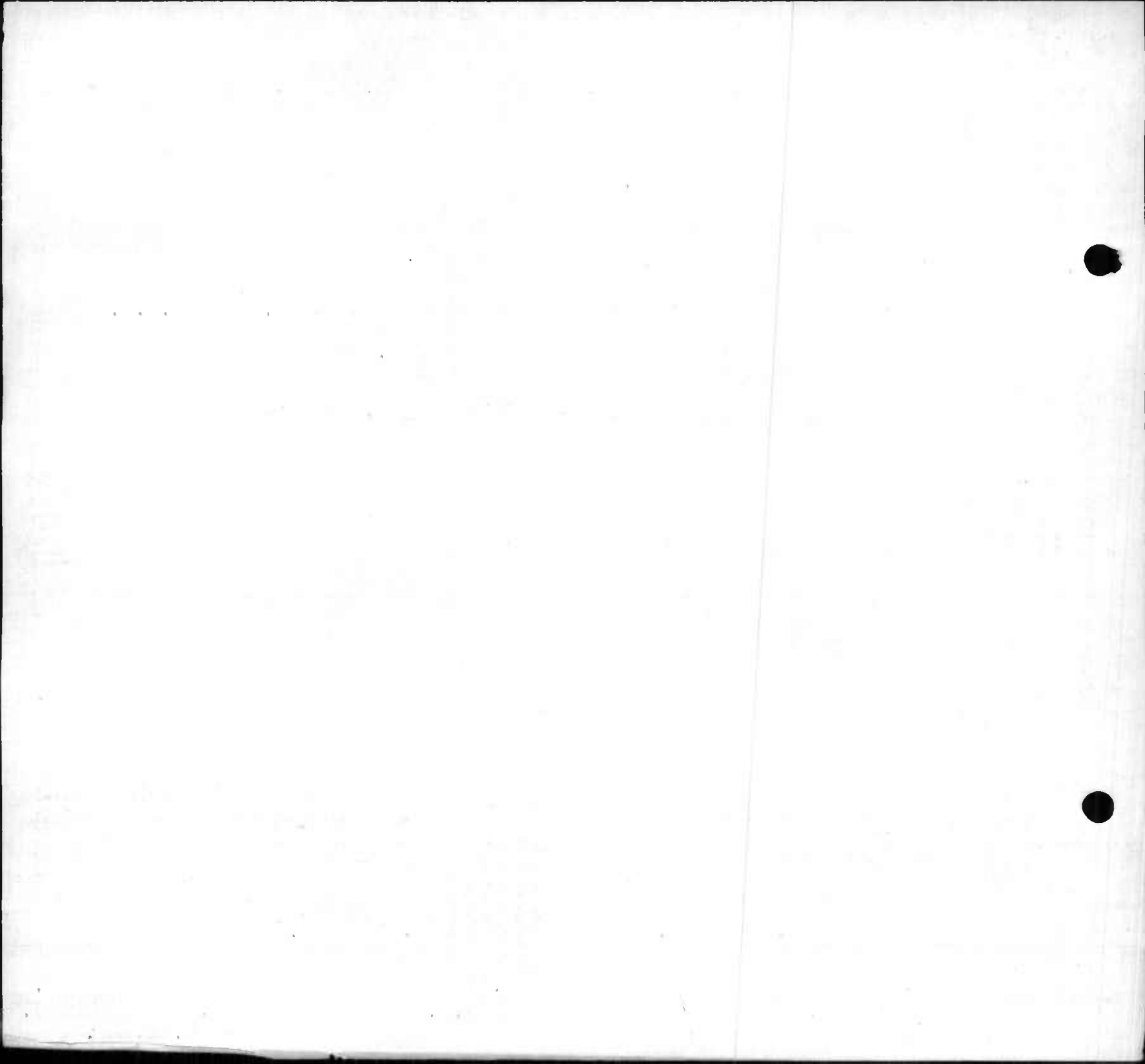


FUNERAL DIRECTOR: IMPORTANT

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| BIRTH NO. 66 04127 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 04127 | |
|---|---------------------|--|--|---|--|---|--|-------------------------|--|
| 1. NAME OF DECEASED
(Type or Print)
Mabel Elizabeth Williar | | | | 2. DATE AND HOUR OF DEATH
April 20, 1966 1 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Ambassador Apts. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 12-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore (18)
D. STREET ADDRESS (If rural, give location)
3811 Canterbury Road | | | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | | 8. DATE OF BIRTH
10/28/1890 | 9. AGE (In years last birthday)
75 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Stablersville, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
John Francis Nelson DeMoss | | | | 14. MOTHER'S MAIDEN NAME
Martha L. Nelson | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
553-44-5759 | | 17. INFORMANT ADDRESS
Stanley W. DeMoss, 823 Winans Way | | | | | |
| 18. 4-22-1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic CVD
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Euphysema | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
2 yrs
3 yrs | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct. 29 19 65 to April 20 19 66 , that (I) (we) last saw the deceased alive on April 19 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Franklin E. Leslie | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4-21-66 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Franklin E. Leslie | | | | 23D. ADDRESS
302 E. 33rd St. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/23/1966 | | 24C. NAME OF CEMETERY or CREMATORY
Western Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 22 1966 | | 25B. NAME OF REGISTRAR
W. E. Jenkins | | 25C. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. | | ADDRESS
4905 York Rd. Balto. 12, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| CITY HEALTH DEPARTMENT | | | | REGISTERED | |
|--|------------------|--|-----------------------------------|--|--|
| BIRTH NO. 66 04128 | | CERTIFICATE OF DEATH | | Registered No. 66 04128 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Anna Heubeck Knipp | | April 20, 1966 11:45 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. (If institution: residence before admission)
A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

Tudor Arms Apts. | | Maryland | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) | | 501 W. University Pkwy. | |
| 5. SEX

F | 6. RACE

W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed | 8. DATE OF BIRTH

9/13/1870 | 9. AGE (In years last birthday)

95 | 10. CITIZEN OF WHAT COUNTRY?

U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY

Own Home | | 11. BIRTHPLACE (State or foreign country)

Baltimore, Md. | |
| 13. FATHER'S NAME

George F. Heubeck | | 14. MOTHER'S MAIDEN NAME

C. Miller | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No | | 16. SOCIAL SECURITY NO.

216-46-2627 | | 17. INFORMANT ADDRESS

George W. Knipp, 6407 Pinehurst Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO
(B) _____
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH

2 yrs + | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION

O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)

No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>December 1960</u> 19 to <u>April 20</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>April 15</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE

<i>John A. Nesbitt, Jr.</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED

4-21-66 | |
| 23C. PHYSICIAN'S NAME (Type)

John A. Nesbitt, Jr. M.D. | | 23D. ADDRESS

1009 Frederick Road | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)

Burial | | 24B. DATE

4/22/1966 | | 24C. NAME OF CEMETERY or CREMATORY

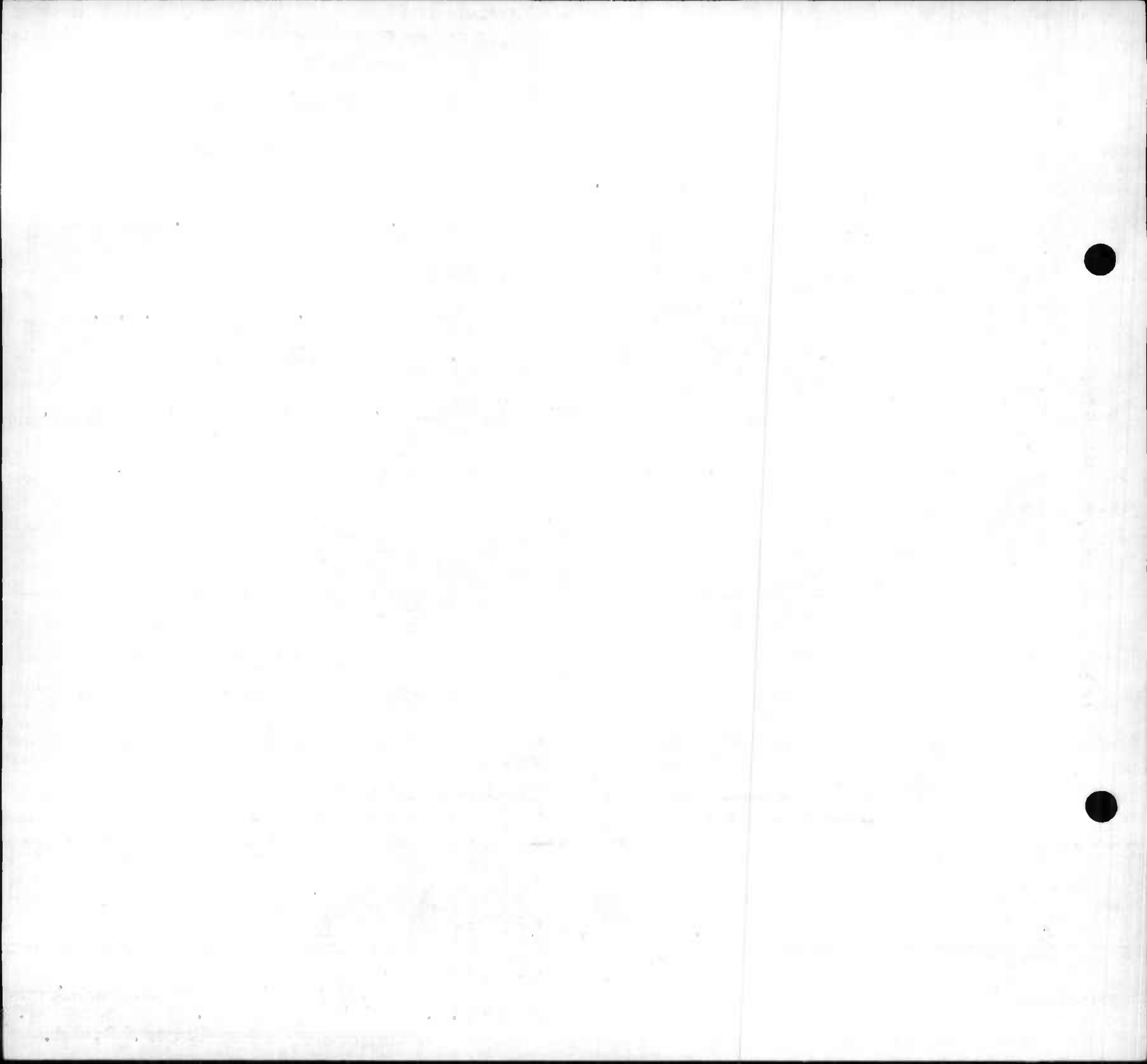
Loudon Park | |
| | | | | 24D. LOCATION (City, town, or county) (State)

Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.

APR 22 1966 | | 25B. NAME OF REGISTRAR

H.W. Jenkins & Sons Co. | | 25C. FUNERAL DIRECTOR ADDRESS

4905 York Rd. Balto. 12, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 66 04129 | |
|---|-------------------------|--|--|---|--|--|---|
| BIRTH NO. 66 04129 | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) YATES, Nellie BRATTEN | | | | 2. DATE AND HOUR OF DEATH
4/19/66 | | 11 ²⁰ P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 27-48 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
North Charles General Hosp. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| D. STREET ADDRESS (If rural, give location)
541 Benninghaus Rd #12 | | | | | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
Mar. 16, 1905 | 9. AGE (in years last birthday)
61 yrs | 10. Under 1 Yr. Months Days | | 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Buyer | | | 10B. KIND OF BUSINESS OR INDUSTRY
Lycett Corp. | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA. |
| 13. FATHER'S NAME
Bratten, Harry F. | | | | 14. MOTHER'S MAIDEN NAME
Percy, Isabelle | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no unknown) (If yes, give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO.
219-28-8527 | | 17. INFORMANT
JAMES B. YATES. | |
| | | | | ADDRESS
705 AMERICAN DRIVE APT. 25 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Bronchial asthma | | | | CAUSE OF DEATH
(A) DUE TO
ventricular anphy. | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Long time steroid therapy with adrenal atrophy | | | | (B) DUE TO | | | |
| (C) DUE TO | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1 1966 to April 19 1966, that (I) (we) last saw the deceased alive on 4-19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Jerome Gaber | | | | M.O. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4-19-66 | |
| 23C. PHYSICIAN'S NAME (Type)
JEROME GABER | | | | 23D. ADDRESS
5706 BELLONA AV BALTO, MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/23/1966 | | 24C. NAME OF CEMETERY or CREMATORY
East New Market | | 24D. LOCATION (City, town, or county) (State)
East New Market, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
H. W. Jenkins & Sons Co. | | 25C. FUNERAL DIRECTOR
4905 York Rd. Balto. 12, Md. | | ADDRESS | |

Don't let the
water get in
the engine
oil

2

10

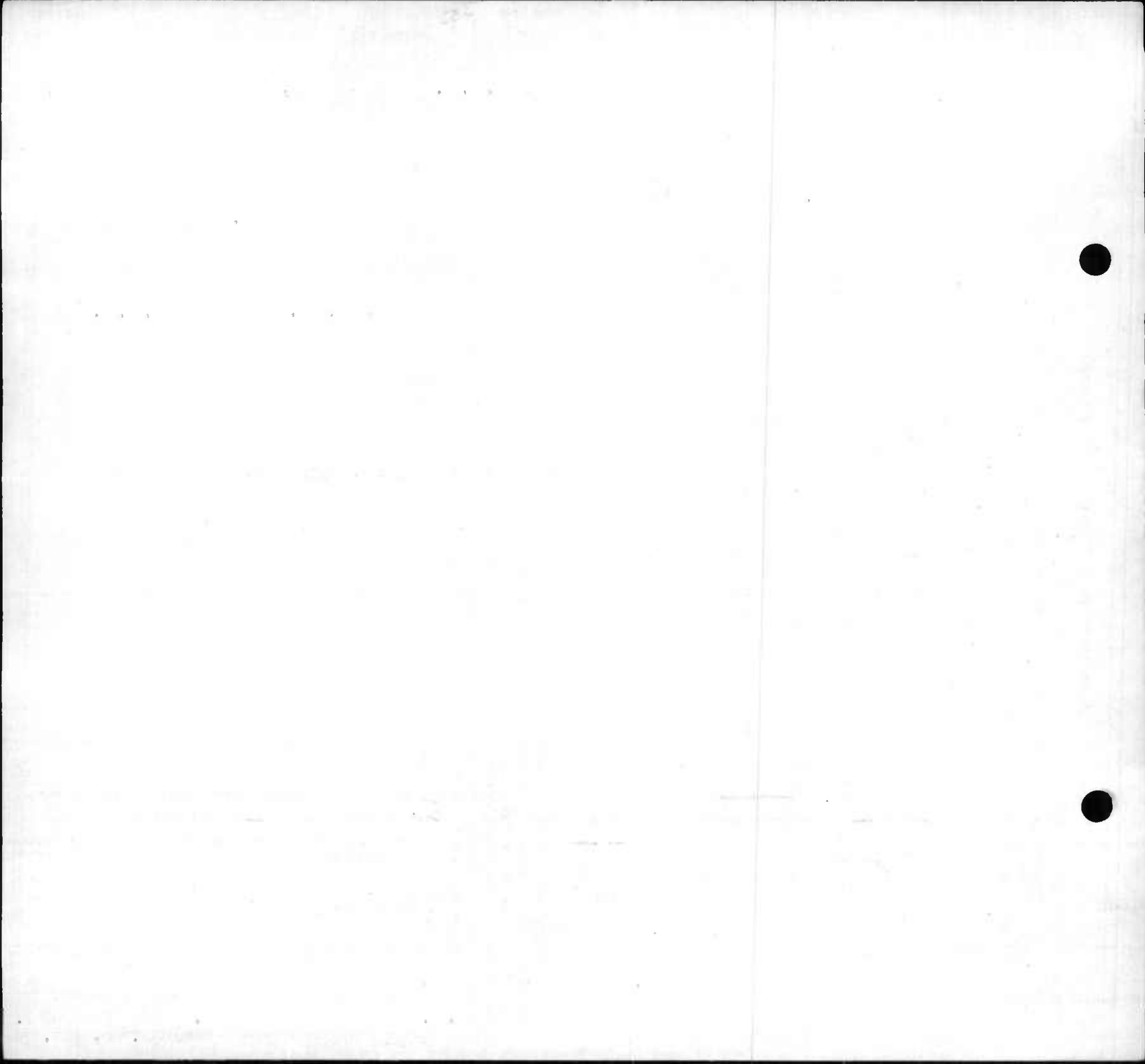
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department
CERTIFICATE OF DEATH | | | | Registered No. 66 04130 | |
|--|--------------|--|---|--|---|
| BIRTH NO. 66 04130 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) Sister Mary Berard Kopp, O.S.F. | | | 2. DATE AND HOUR OF DEATH
April 21, 1966 10:00 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)

94 St. Elizabeth's Home | | | A. STATE
Maryland | | |
| | | | B. COUNTY
9-01 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location)
3725 Ellerslie Ave. | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Never Married | 8. DATE OF BIRTH
2/20/1887 | 9. AGE (In years last birthday)
79 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Nun |
| | | 10B. KIND OF BUSINESS OR INDUSTRY
Religious | 11. BIRTHPLACE (State or foreign country)
Lead City, S. Dakota | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
John Kopp | | | 14. MOTHER'S MAIDEN NAME
Elizabeth Oberle | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
Mother Mary Alexander (Same) | | |
| 18. 422111
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic Cardio-Vascular Disease | | | CAUSE OF DEATH
INTERVAL BETWEEN ONSET AND DEATH
2 years | | |
| 19. 422111
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 1950 to April 1966, that (I) (was) last saw the deceased alive on March 22, 1966, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Com. H. Kammerer, M.D. | | | | 23B. DATE SIGNED
22 April 66 | |
| 23C. PHYSICIAN'S NAME (Type)
William H. Kammerer, M.D. | | | 23D. ADDRESS
6011 York Road | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/25/1966 | | 24C. NAME OF CEMETERY OR CREMATORY
St. Elizabeth's Convent | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 22 1966 | | 25B. NAME OF REGISTRAR
A. E. Taylor | | 25C. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. | |
| | | | | ADDRESS
4905 York Rd. Balto. 12, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|---------|--|--|------------------------------------|---|--|---|--|---|---------------------------------|
| 66 04131 CERTIFICATE OF DEATH | | | | | Registered No. 66 04131 | | | | | |
| BIRTH NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| M.E. CASE NO. | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| Mrs. Viola Bell | | | | | April 21, 1966 8:35a M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital
1514 Division Street
Baltimore, Maryland 21217 | | | | | A. STATE
Maryland | | | | | |
| | | | | | B. COUNTY | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
2002 Presstman Street | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | 10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF
WHAT COUNTRY? |
| Female | Negro | Widowed | Jan. 5, 1899 | 67 | Domestic | Pvt. Family | Maryland | U.S.A. | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Oscar Bowser | | | | | Florence Hall | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| | | | | | 214-30-2529 | | Robert Bell-son | | Phone 728-0172 same | |
| 18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | | | CAUSE OF DEATH | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) Carcinoma of breast with wide spread metastasis | | | | | |
| | | | | | (B) DUE TO | | | | | |
| | | | | | (C) DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| O | | | Carcinoma of breast | | | no | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| | | | | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED | | | 21F. HOW DID INJURY OCCUR? | | | | |
| | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 19, 1966 to April 21, 1966, that (I) (we) last saw the deceased alive on April 21, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE | | | | | | | | 23B. DATE SIGNED | | |
|  | | | | | | | | April 21, 1966 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS | | | | | |
| G. Moondae | | | | | 1514 Division Street-Baltimore 17, Maryland | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 4/25/66 | | Mount Auburn Cemetery | | | Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR | | | 25C. FUNERAL DIRECTOR ADDRESS | | | | |
| APR 22 1966 | | | Herbert E. Nutter | | | 3035 W. North Ave | | | | |

Division of Investigation
Baltimore, Maryland 21201

Re: [illegible] [illegible] [illegible]

[illegible]

Robert Bell - non [illegible]

[illegible]

Section of [illegible]

[illegible]

[Handwritten signature]

[illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REGISTERED NO. 66 04132 | |
|--|--|---|--|--|--|
| BIRTH NO. 66 04132 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print)
WILLIAM GRANT | | | 2. DATE AND HOUR OF DEATH
4-19-66 4:20 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

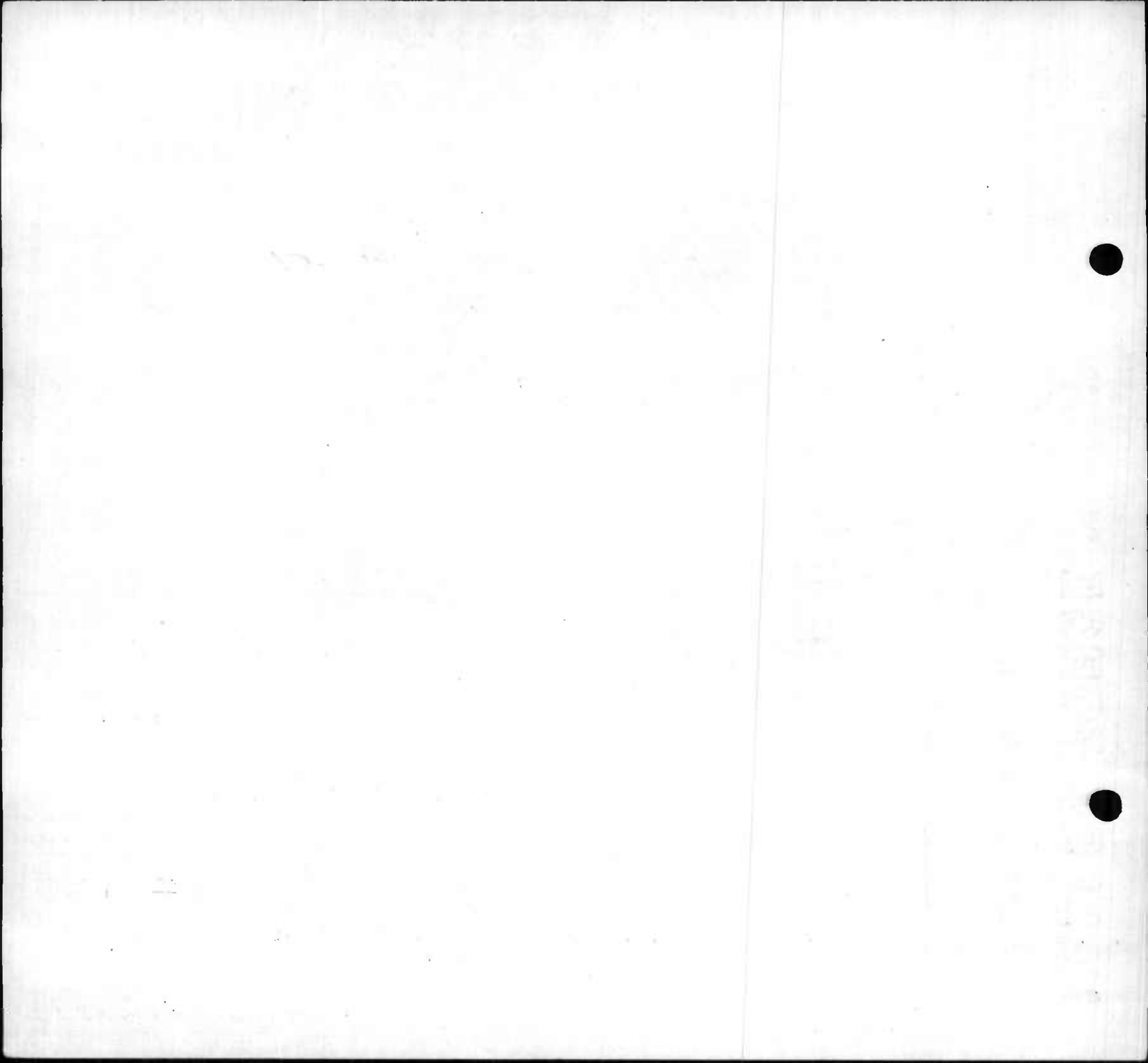
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
36 FRANKLIN SQUARE HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY 16-02 | | |
| 5. SEX M | | | 6. RACE Negro | | 7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED
<input type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify)
Married |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Stock Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY
Marine Supply | | 8. DATE OF BIRTH
11/28/1895 | |
| 11. BIRTHPLACE (State or foreign country)
South Carolina | | 9. AGE (In years last birthday)
70 YRS | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Sophold Grant | | | 14. MOTHER'S MAIDEN NAME
? ? ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes World War 1 | | 16. SOCIAL SECURITY NO.
212-03-3696 | | 17. INFORMANT
Annie Jackson 210 Mason Ct. | |
| 18. 491 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
brucella pneumonia, hypertension
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
heart disease complicating gastrostomy | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 3 1966 to APRIL 19 1966 , that (I) (we) last saw the deceased alive on APRIL 19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
WILFREDO M. MEDIANO | | | | 23B. DATE SIGNED
APRIL 19, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
WILFREDO M. MEDIANO | | | | 23D. ADDRESS
FRANKLIN SQUARE HOSP. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/25/66 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
APR 22 1966 | | | |
| 25B. NAME OF REGISTRAR
Herbert E. Nutter | | 25C. FUNERAL DIRECTOR
Herbert E. Nutter-3035 W. North Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|-----------|--|--|---|--|--------------------------------|--|--|
| 66 04133 | | | | | REGISTERED NO. | | 66 04133 | | |
| BIRTH NO. 66 04133 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| CLEO H. LUMPKIN | | | | | APRIL 21 - 1966 6:00 P. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | A. STATE B. COUNTY | | | | |
| DO 1716 HARLEM AVE | | | | | MD 16-03 | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | D. STREET ADDRESS (If rural, give location) | | | | |
| BALTIMORE | | | | | 1716 HARLEM AVE | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years lost birth) | |
| F | | COL | | MARRIED | | MAY 3 - 1914 | | 51 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Domestic | | | | Pur Family | | Atlanta Ga. | | USA | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | |
| JOHN HARRIS | | | | | MINNIE HARRIS | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| NO | | | | | 260-26-4584 | | GEORGE LUMPKIN 1716 HARLEM AVE | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | CAUSE OF DEATH | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) DUE TO | | | | |
| HYPERTENSIVE CARDIO VASCULAR DISEASE | | | | | 3 months | | | | |
| 19. ANTECEDENT CAUSES | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) DUE TO | | | | |
| (C) DUE TO | | | | | (D) DUE TO | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| O | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/19/66 19 to 4/21/66 19, that (I) (we) last saw the deceased alive on 4/21/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | | | | 23B. DATE SIGNED | | |
| Ralph W. Reckling M.D. | | | | | | | April 22, 1966 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS | | | | |
| Ralph W. Reckling M.D. | | | | | 426 N. Gilmore Street | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) | | (State) | |
| Burial | | 4/26/66 | | Mt Auburn | | Baltimore | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| APR 25 1966 | | | | Robert E. Taylor | | Marjorie A. Taylor 638 N. Gilmore St | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04134 | |
|---|---------------|--|-------------------------------|---|--|
| BIRTH NO. 66 04134 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED JACQUELINE CRUM LEFFINGWELL WOOD | |
| (Type or Print) MRS. JACQUELINE WOOD | | | | 2. DATE AND HOUR OF DEATH 4/22/66 4:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | A. STATE Maryland B. COUNTY Baltimore | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dumdalk | |
| | | | | D. STREET ADDRESS (If rural, give location) 1903 Marsdale Road 21222 | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH Nov. 16 1923 | 9. AGE (In years last birthday) 42 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Payroll Clerk, | | 10B. KIND OF BUSINESS OR INDUSTRY Lebow Clothing Co. | | 11. BIRTHPLACE (State or foreign country) New York | |
| 13. FATHER'S NAME Lewis Grunberg | | | | 14. MOTHER'S MAIDEN NAME Marie Grum | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes, Navy, WWII | | | | 16. SOCIAL SECURITY NO. 090-12-8051 | |
| | | | | 17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224 | |
| 18. 42011 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Myocard Infarction (B) Cardiac Arrest. (C) | |
| INTERVAL BETWEEN ONSET AND DEATH 2 hrs - 40 min | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/22/66 19 to 4/22/66 19 that (I) (we) last saw the deceased alive on 4/22/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] M.D. | | | | 23B. DATE SIGNED 4/22/66 | |
| 23C. PHYSICIAN'S NAME (Type) M. R. Doeh | | | | 23D. ADDRESS M.D. 1903 E. 4940 Eastern Avenue 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE April 26-1966 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National, Baltimore, Maryland 21228 | |
| 25A. DATE RECD BY HEALTH DEPT. APR 25 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR JOHN J. DUDA, Dumdalk, Maryland 21222 | |

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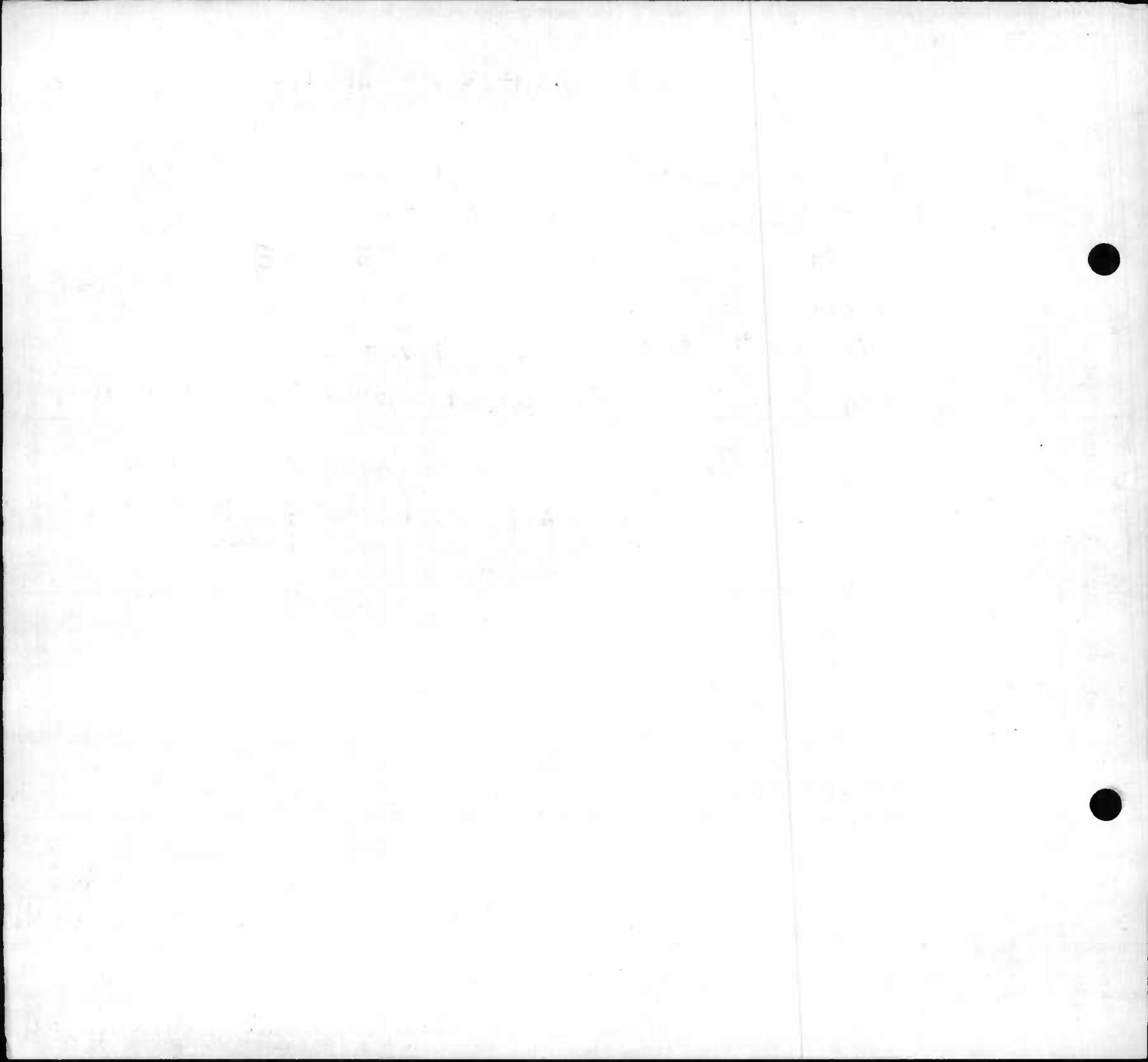
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|---|--|---------------------|--|--|---|------------------------------------|--|--|--|---|--|-----------------------------|--|--|
| BIRTH NO. 66 04135 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 04135 | | | | |
| 1. NAME OF DECEASED
(Type or Print) George Washington Whittaker | | | | | 2. DATE AND HOUR OF DEATH
4/20/66 12:45 A.M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Carroll | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
University Hospital
Bolto. Md. | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Sykesville
56-00 | | | | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
Route 3 | | | | | | | | | |
| 5. SEX
Male | | 6. RACE
N | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
3-12-83 | | 9. AGE (In years last birthday)
83(83) | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Farming | | | | | 11. BIRTHPLACE (State or foreign country)
Maryland | | | | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | 13. FATHER'S NAME
Louis Whittaker | | | | | 14. MOTHER'S MAIDEN NAME
Martha | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNKNOWN No | | | | | 16. SOCIAL SECURITY NO.
217 36 2938 | | | | | 17. INFORMANT
R. E. Stoner ADDRESS
University Hospital | | | | |
| 18. 4-20-66
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH
(A) Broncho pneumonia
DUE TO
(B) Arteriosclerotic Heart Disease
DUE TO
(C) | | | | | INTERVAL BETWEEN ONSET AND DEATH
Days
Years | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No)
Yes | | | | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | 22. I certify that (I) (this hospital) attended the deceased from 4/13/66 19 66 to 4/20/66 19 66 that (I) (we) last saw the deceased alive on 4/20 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Robert E. Stoner, M.D. | | | | | 23B. DATE SIGNED
4/20/66 | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
Robert E. Stoner | | | | | 23D. ADDRESS
M.D. University Hospital, Balto Md | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | | 24B. DATE
4-23-66 | | | | | 24C. NAME OF CEMETERY or CREMATORY
Johnsville Cemetery | | | | |
| 24D. LOCATION (City, town, or county) (State)
Sykesville Md. | | | | | 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | | | | 25B. NAME OF REGISTRAR
Robert E. Stoner | | | | |
| 25C. FUNERAL DIRECTOR
Harry W. Haight | | | | | 25D. ADDRESS
Sykesville, Md. | | | | | | | | | |

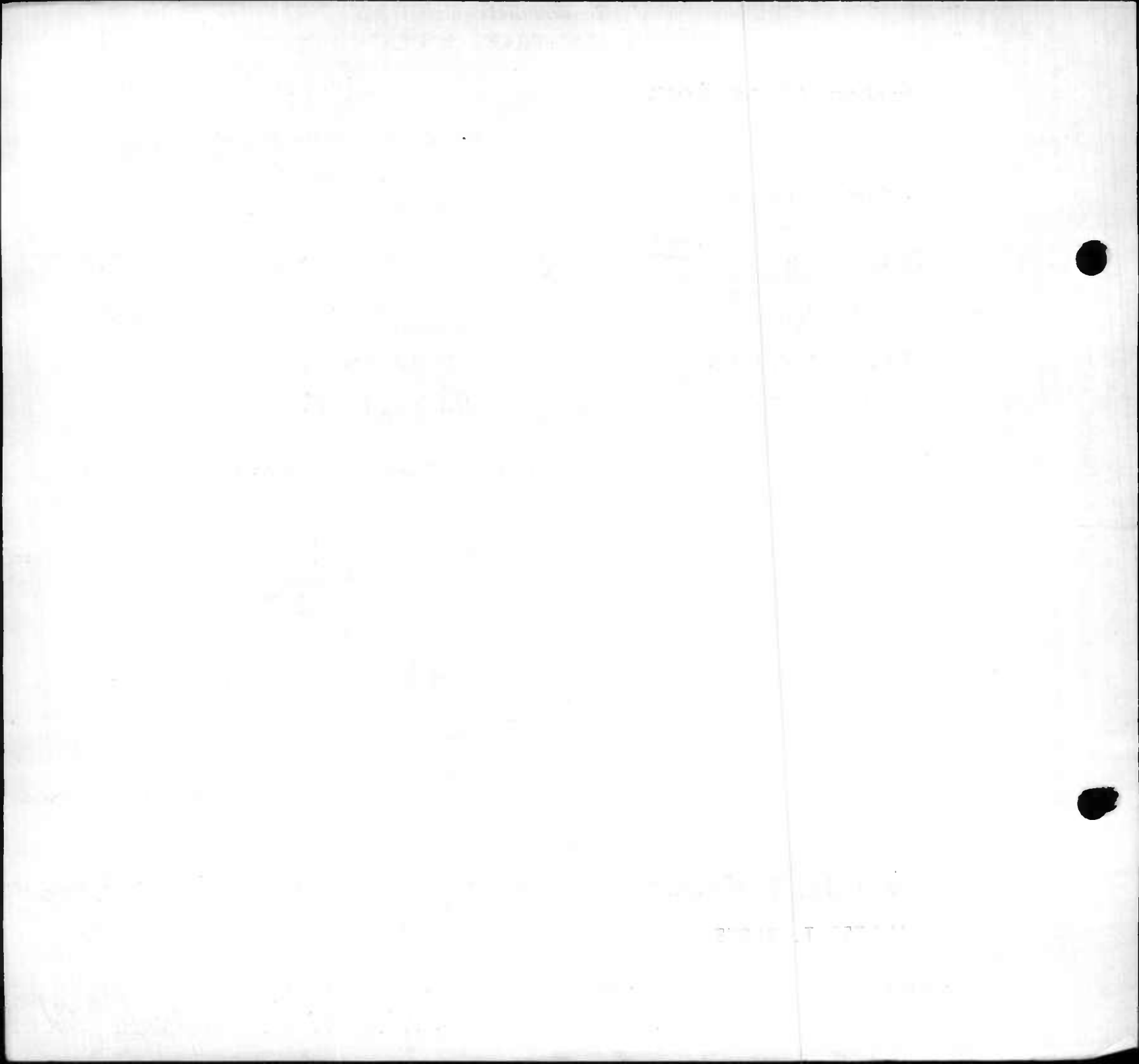


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|------------------------------------|--|--|
| BIRTH NO. 66 04138 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04138 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) LAURA LOUISE Rhoton | | 2. DATE AND HOUR OF DEATH
4/19/66 9:50 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

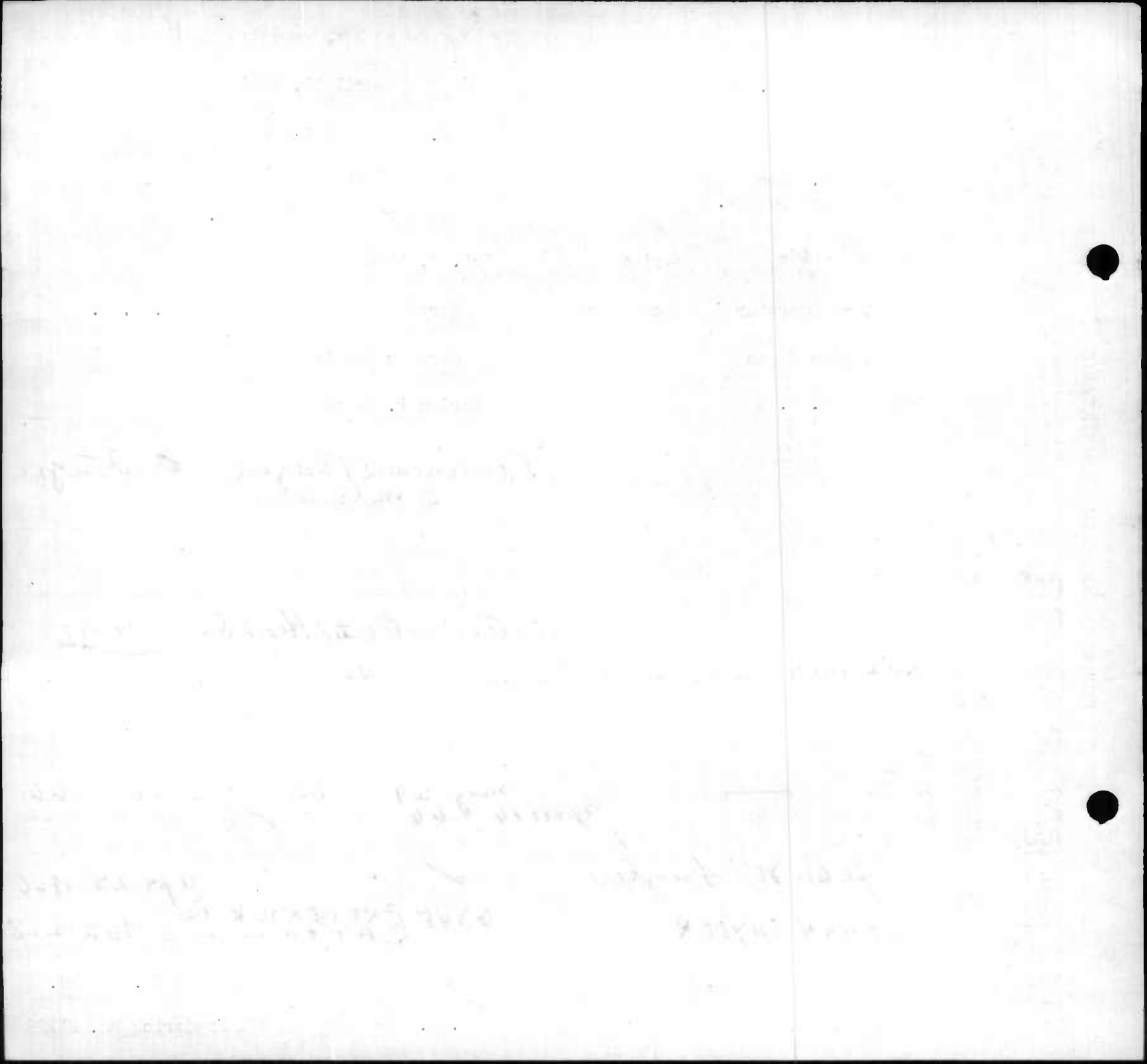
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Union Memorial Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Baltimore Maryland B. COUNTY 13-08
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3814 Falls Road | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
<input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED (specify) | 8. DATE OF BIRTH
5/5/184 | 9. AGE (In years last birthday)
81 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
USA | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Elias McKimley | | 14. MOTHER'S MAIDEN NAME
Louise Deery | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT ADDRESS
Hospital Records | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
hypertension | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
26 day | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from March 25, 1966 to April 17, 1966 , that (I) (we) last saw the deceased alive on April 18, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Walter T. Boone | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
April 19, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
WALTER T. BOONE | | 23D. ADDRESS
M.D. Union Memorial Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-22-66 | | 24C. NAME OF CEMETERY or CREMATORY
Monocacy Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Beallsville, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
Harry W. Haight, Sykesville, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

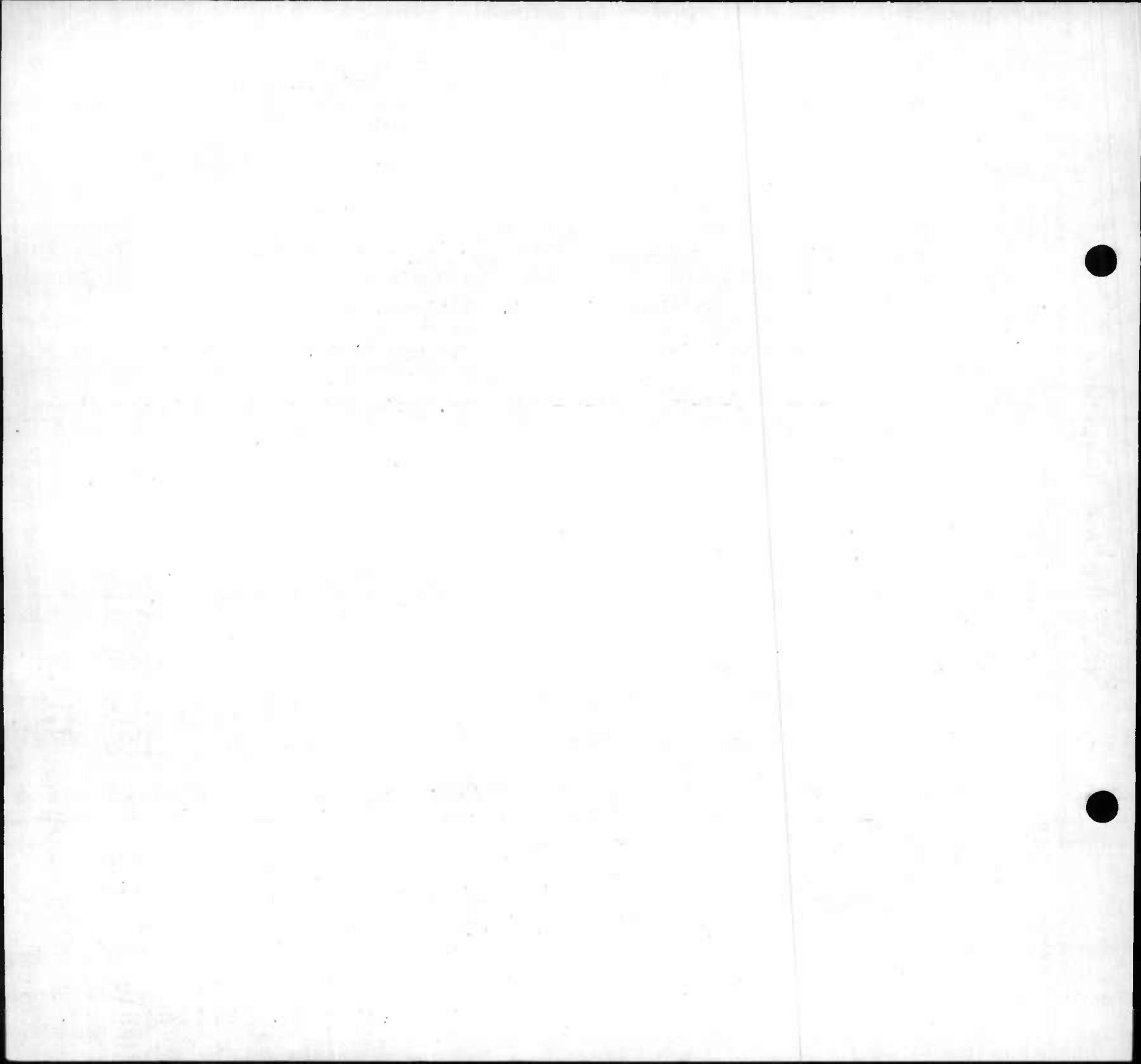
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 04137</u> | |
|---|-------------------------|---|---|--|---|
| BIRTH NO. <u>66 04137</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Harry C. Hagan</u> | | 2. DATE AND HOUR OF DEATH
<u>April 21, 1966</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Hood Conv. Home</u>
<u>5313 Edmondson Ave.</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Catonsville</u>
D. STREET ADDRESS (If rural, give location)
<u>111 North Symington Ave.</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>Oct. 8, 1894</u> | 9. AGE (In years last birthday)
<u>71</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Pari Mutuel Operator</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Race Track</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | 13. FATHER'S NAME
<u>Washington Hagan</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Mc Kenzie</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>Yes</u> <u>W. W. I</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Marian B. Hagan</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Carcinoma Tongue</u>
<u>metastasis</u> | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 1/2 yrs.</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>Arteriosclerotic Heart Dis</u> | | <u>4 yrs.</u> | |
| 19A. DATE OF OPERATION
<u>Nov. 1963</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>CARCINOMA TONGUE</u> | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>May 29</u> 19 <u>62</u> to <u>Apr 21</u> 19 <u>66</u> . that (I) (we) last saw the deceased alive on <u>April 14</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>John N. Snyder</u> | | | | 23B. DATE SIGNED
<u>Apr 22, 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>JOHN N. SNYDER</u> | | 23D. ADDRESS
<u>6348 FREDERICK RD</u>
<u>CATONSVILLE MD 21228</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>April 25, 66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Grace Episcopal Church</u> | |
| 24D. LOCATION
<u>Elkridge</u> | | <u>Howard Co.</u> | | <u>Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 25 1966</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. ...</u> | | 25C. FUNERAL DIRECTOR
<u>E. S. Mac Nabb</u> | |
| | | | | ADDRESS
<u>301 Frederick Rd. 21228</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04138 | |
|---|------------------|---|--|---|---|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 66 04138 CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) JOHN SCHILLING | | | 2. DATE AND HOUR OF DEATH
April 22, 1966 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
1819 Aliceanna Street | | | A. STATE Maryland
B. COUNTY 203
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1819 Aliceanna Street | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Separated | 8. DATE OF BIRTH
April 22, 1897 | 9. AGE (In years last birthday)
69 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY
Baltimore Fire Dept. | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | |
| 13. FATHER'S NAME
Thomas Schilling | | | 14. MOTHER'S MAIDEN NAME
Margaret Lindeman | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 6-20-16 2-25-19 | | 16. SOCIAL SECURITY NO.
217-26-1193 | | 17. INFORMANT
Mrs. Marie Walters 1819 Aliceanna Street | |
| 18. 420.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
ARTERIOSCLEROTIC HEART DISEASE 10 yrs | | INTERVAL BETWEEN ONSET AND DEATH |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MAY 3 1960 to APRIL 22 1966, that (I) last saw the deceased alive on APRIL 22 1966 and that in (my) opinion death occurred on the date and hour and from the causes noted above. (I) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
S. B. Kaplan | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/22/66 |
| 23C. PHYSICIAN'S NAME (Type)
S. B. Kaplan | | | 23D. ADDRESS
129 S. BROADWAY BALTO MD. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-26-1966 | | 24C. NAME OF CEMETERY or CREMATORY
Moreland Memorial Park | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore County, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | 25B. NAME OF REGISTRAR
Robert E. Fink | | 25C. FUNERAL DIRECTOR
Lilly & Zeiler Inc. 1901 Eastern Ave. | |



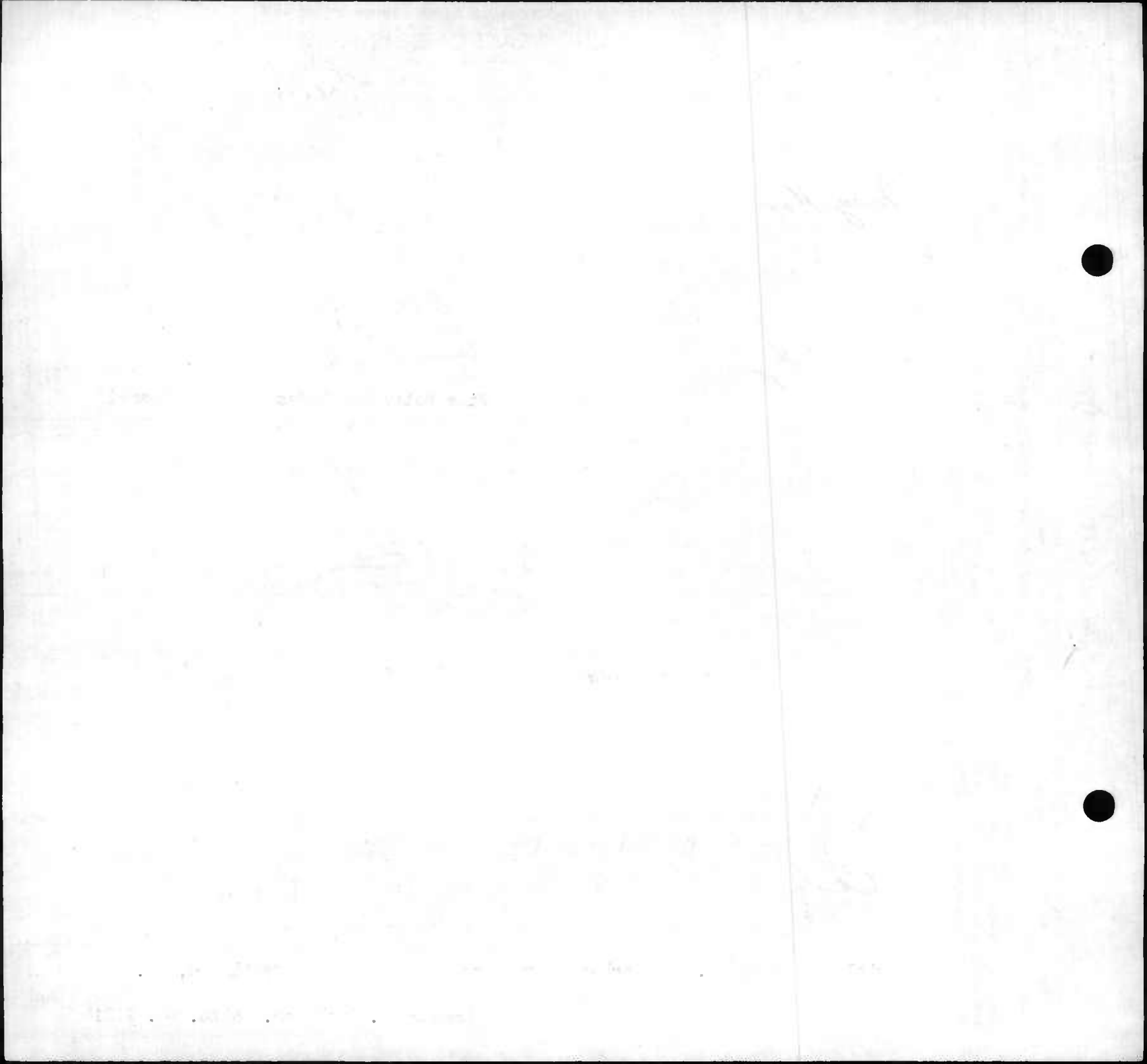
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------------|--|--|--|--|--|--|--|--|
| Certificate of Death | | | | | Registered No. 66 04139 | | | | |
| BIRTH NO. 66 04139 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Mary C. Hodes</i> | | | | | 2. DATE AND HOUR OF DEATH
<i>4/21/66</i> <i>151</i> P. M. | | | | |
| 3. PLACE OF DEATH IN <i>BALTIMORE, MARYLAND</i> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>md</i> B. COUNTY <i>27-05</i> | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>37 Mary Hodes</i> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Balto</i> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
<i>3010 Northern Parkway</i> | | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Widowed</i> | 8. DATE OF BIRTH
<i>12/8/1955</i> | 9. AGE (In years last birthday)
<i>70</i> | If Under 1 Yr. Months: Days: | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>-</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Balto, Md.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | |
| 13. FATHER'S NAME
<i>John Saffey</i> | | | | | 14. MOTHER'S MAIDEN NAME
<i>Anne Camble</i> | | | | |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>NO</i> | | | 16. SOCIAL SECURITY NO.
<i>-</i> | | 17. INFORMANT
<i>Miss Betty Ann Hodes</i> | | ADDRESS (Same)
<i>(Same)</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | CAUSE OF DEATH
(A) <i>Myocardial Infarction</i>
DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
<i>24 hours</i> | | |
| | | | | | (B) <i>Ischemic Obstruction, Myocardial</i>
DUE TO
<i>Arteriosclerosis, Coronary, Cholesterol</i> | | <i>8 min</i> | | |
| 19A. DATE OF OPERATION
<i>4/20/66</i> | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Small Intestine Obstr.</i> | | 20A. AUTOPSY? (Yes or No)
<i>Yes</i> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4/17/66</i> 19 to <i>4/21/66</i> 19, that (I) (we) last saw the deceased alive on <i>4/21/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<i>Chas. C. Collins M.D.</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>4/21/66</i> | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Chas. C. Collins</i> | | | | | 23D. ADDRESS
<i>Mary Hodes</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>4/25/66</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Parkwood Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>APR 25 1966</i> | | | 25B. NAME OF REGISTRAR
<i>Robert E. Stanley, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>Leonard J. Ruck Inc.</i> | | | | |
| | | | | | ADDRESS
<i>Balto. Md. 21214</i> | | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANNABELLE CONNER

2. DATE AND HOUR PRONOUNCED DEAD

April 23, 1966

12:25 AM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

MERCY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE North Carolina B. COUNTY V-30

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Mullins

D. STREET ADDRESS (If rural, give location)

421 Valentine St.

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Unknown

8. DATE OF BIRTH

Jan 1, 1902

9. AGE (In years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unknown

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wm. Blackman

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

Unknown

17. INFORMANT

ADDRESS

Jackson Funeral Home - Marion, S.C.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Bronchopneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenacker, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-23-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/27/66

23C. NAME OF CEMETERY or CREMATORY

Jackson & Daughters

23D. LOCATION

(City, town, or county)

(State)

Marion, S.C.

24A. DATE REC'D BY HEALTH DEPT.

APR 25 1966

24B. NAME OF REGISTRAR

Robert L. Farkner

24C. FUNERAL DIRECTOR

Wm. L. Bohatman

ADDRESS

1701 W. McCulloch St.

Baltimore, Md.

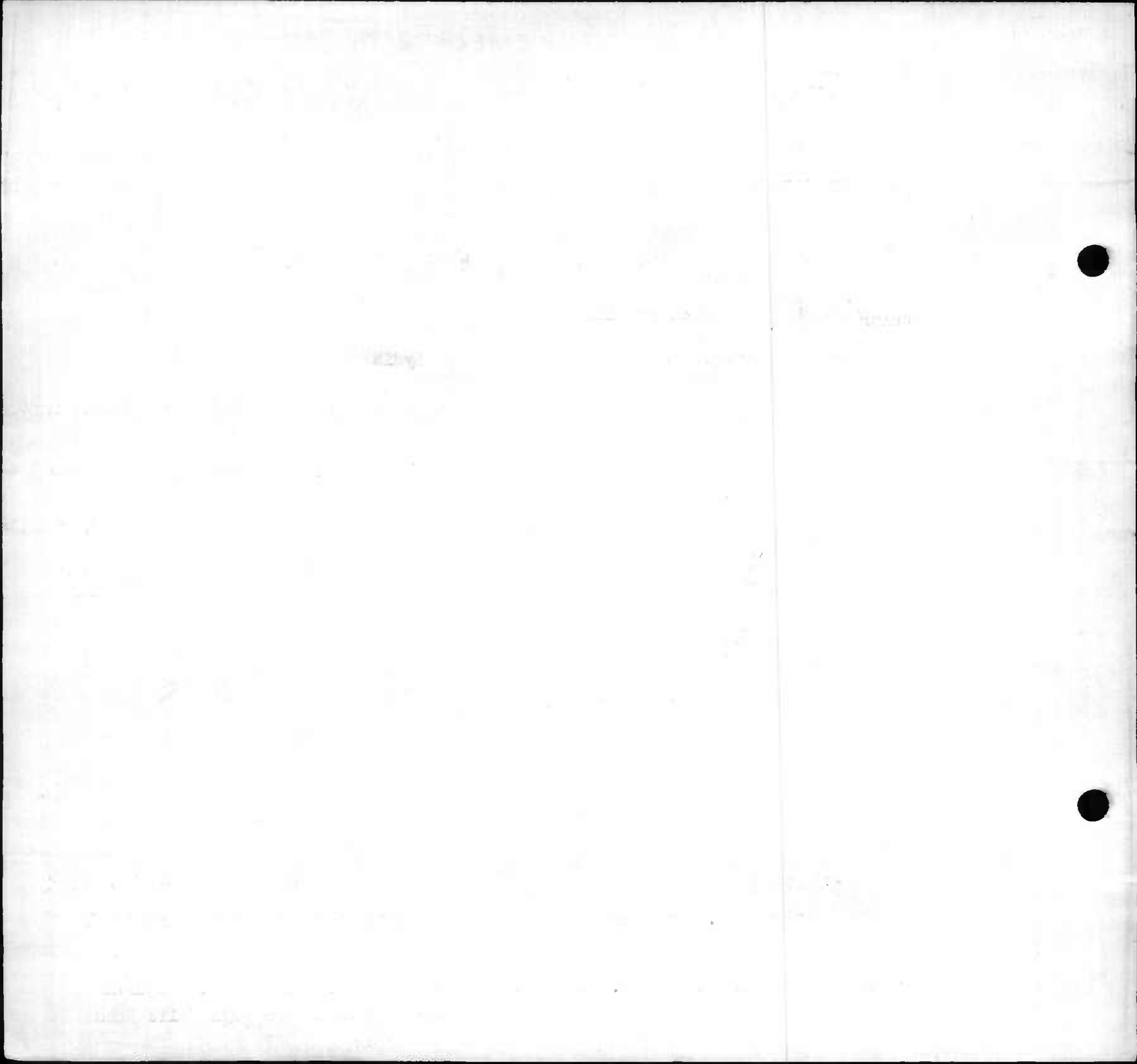
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 04141</u> | |
|---|---------------------|--|------------------------------------|--|---|
| BIRTH NO. <u>66 04141</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Tracey Ruth Elaine</u> | | 2. DATE AND HOUR OF DEATH
<u>4/21/66</u> <u>4:30 PM.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Montebello State Hospital</u> | | A. STATE <u>Maryland</u> B. COUNTY <u>1308</u> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>3512 Buena Vista Ave.</u> | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>married</u> | 8. DATE OF BIRTH
<u>4/23/20</u> | 9. AGE (In years
last birthday)
<u>45</u> | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Spooler</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Cotton Mill</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | 13. FATHER'S NAME
<u>William Gorsuck</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Lydia Williams</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<u>Vernon Tracey 3512 Buena Vista</u> | | | |
| 18. <u>180X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

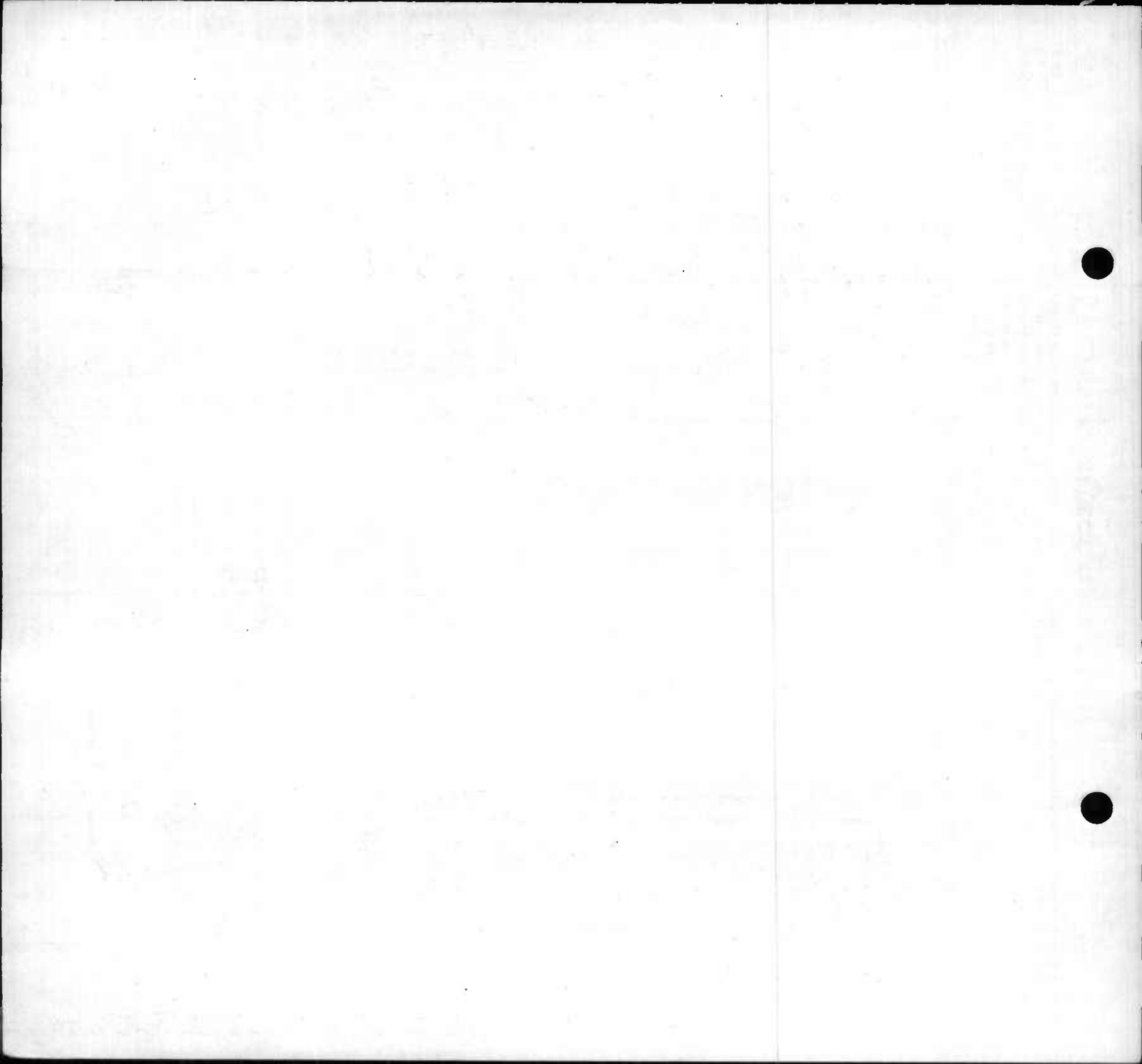
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <u>Bilateral pneumonia</u>
DUE TO
(B) <u>renal cell carcinoma</u>
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 wks</u>
<u>3 yrs</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>yes</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>no</u> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>4/6</u> 19 <u>66</u> to <u>4/21</u> 19 <u>66</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>4/21</u> 19 <u>66</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Robert W. Ireland</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>4/21/66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Robert W. Ireland</u> | | 23D. ADDRESS
<u>Montebello State Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>April 26, 1966</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Mt. Pleasant Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Carroll County, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 25 1966</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Ireland</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>Burgee Funeral Home 3631 Falls Road</u> | | | |
| VS 150-REV. 1/1/65 | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|-------------------------|---|-------------------------------------|---|---|
| 66 04142 | | CERTIFICATE OF DEATH | | 66 04142 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Joseph H. Witzler</i> | | 2. DATE AND HOUR OF DEATH
<i>April 22, 1966 3 9. M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>1903</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>410 S. Calhoun St.</i> | | D. STREET ADDRESS (If rural, give location)
<i>410 S. Calhoun St.</i> | | | |
| 5. SEX
<i>Male</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Widowed</i> | 8. DATE OF BIRTH
<i>12/17/99</i> | 9. AGE (In years last birthday)
<i>66</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Welder</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>B. & O. R.R.</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> | | 13. FATHER'S NAME
<i>Unknown</i> | | 14. MOTHER'S MAIDEN NAME
<i>Unknown</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>Yes W.W.I</i> | | 16. SOCIAL SECURITY NO.
<i>705-12-4408</i> | | 17. INFORMANT
<i>Lydian C. Witzler</i> | |
| 18. <i>420.1 I</i> | | CAUSE OF DEATH | | ADDRESS
<i>410 S. Calhoun St.</i> | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO
<i>CORONARY OCCLUSION</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>ACUTE</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <i>ASTHMA, CHRONIC BRONCHIAL</i> | | <i>37 years</i> | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>April 15, 1966</i> to <i>April 22, 1966</i> that (I) (we) last saw the deceased alive on <i>April 21, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Gilbert E. Rudman</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>4/22/66</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>GILBERT E. RUDMAN</i> | | 23D. ADDRESS
<i>2517 W. BALTO. ST.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>4/25/66</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Burial Hill Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Maryland</i> | | | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
<i>APR 25 1966</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. ...</i> | | 25C. FUNERAL DIRECTOR
<i>Walter Funeral Home Pratt & Stricker St.</i> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <u>K-150</u> <u>66 04143</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>66 04143</u> | |
|--|------------------|--|--|--|---|
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <u>KATHERINE E KEAVNEY</u> | | | 2. DATE AND HOUR OF DEATH
<u>21 Apr 66</u> <u>8:30 P.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
<u>BALTIMORE CITY HOSPITALS</u>
<u>4940 EASTERN AVENUE</u>
<u>BALTIMORE MARYLAND 21224</u> | | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore City</u> <u>9-01</u> | | |
| | | | D. STREET ADDRESS (If rural, give location)
<u>3748 Old York Rd</u> <u>21218</u> | | |
| 5. SEX <u>FM</u> | 6. RACE <u>W</u> | 7. MARRIED-NEVER MARRIED
<u>WIDOWED, DIVORCED</u> (specify) | 8. DATE OF BIRTH
<u>11-24-93</u> | 9. AGE (In years last birthday) <u>72</u> | If Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 13. FATHER'S NAME
<u>JOHN A. CASEY</u> | | 14. MOTHER'S MAIDEN NAME
<u>MARGARET GENN</u> | | 12. CITIZEN OF WHAT COUNTRY
<u>USA</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>NOISE</u> | | 17. INFORMANT
<u>RECORDS: BCH 4940 Eastern Avenue</u>
<u>Son</u> <u>Baltimore, Md. 21224</u> | |
| 18. <u>450.11x260X</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) DUE TO <u>Septicemia</u>
(B) DUE TO <u>Gangrene @ foot</u>
(C) <u>Arterio Sclerosis Obliterans</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 days</u>
<u>12 days</u>
<u>long</u> |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>Diabetes Mellitus</u> <u>long</u> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Feb 21</u> 19 <u>66</u> to <u>21 Apr</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>21 Apr</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (Yes) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>D. Fairbanks</u> M.D. | | | | 23B. DATE SIGNED
<u>21 Apr 66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>D. F. FAIRBANKS</u> M.D. | | | | 23D. ADDRESS
<u>4940 Eastern Avenue, Balto. Md. 21224</u>
<u>Baltimore City Hospitals</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4-25-66</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>NEW CATHEDRAL CEM.</u> | |
| 24D. LOCATION
<u>BALTO</u> | | 24E. (City, town, or county)
<u>MD</u> | | 24F. (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 25 1966</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Fairbanks</u> | | 25C. FUNERAL DIRECTOR
<u>C. F. EVANS + SON 8802 HANCOCK RD</u> | |

11-28-93
2445 111 1st St
Franklin, N.J.
Mailing
11-28-93

Margaret
MARGARET CLEW
11-28-93

Director
Arthur J. Evers
Comptroller
George J. Evers

11-28-93
11-28-93
11-28-93

11-28-93
11-28-93
11-28-93

11-28-93
11-28-93
11-28-93

FUNERAL DIRECTOR: IMPORTANT

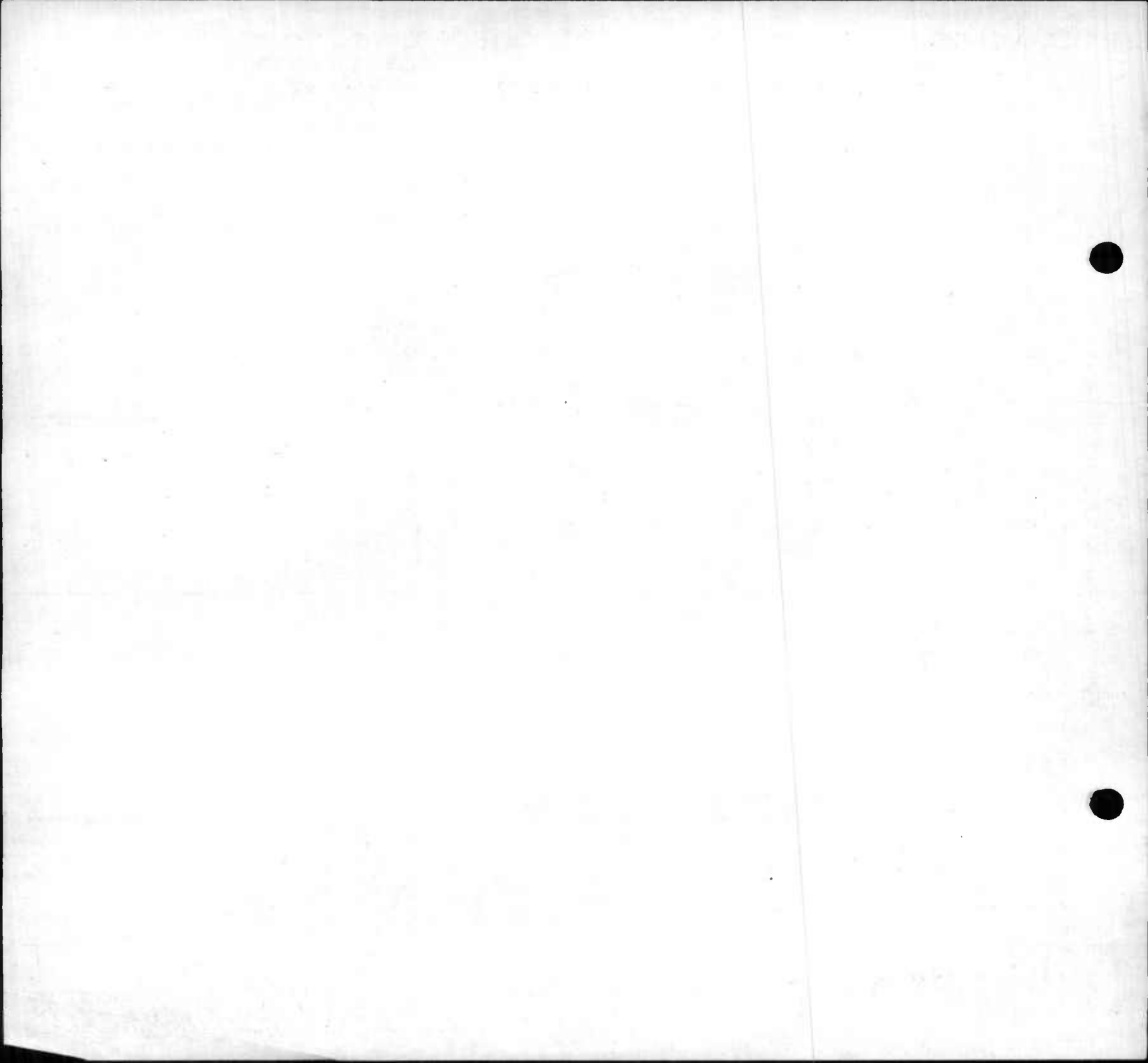
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 66 04144 | | CITY OF BALTIMORE
DEPARTMENT OF HEALTH | | Registered No. 66 04144 | |
|---|------------------|---|---|--|---|--|-------------------------------------|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) | | | |
| | | | | JOSEPH WAYMON TINSLEY | | | |
| 2. DATE AND HOUR OF DEATH | | | | 4/22/66 12:45 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)

UNIVERSITY HOSPITAL | | | | A. STATE
Md. | | | |
| | | | | B. COUNTY
BALTO. | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| D. STREET ADDRESS (If rural, give location)
1809 W. MULBERRY ST. | | | | | | | |
| 5. SEX
M | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
4-12-99 | 9. AGE (In years last birthday)
67 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
UNEMPLOYED | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
RUBIN TINSLEY | | | 14. MOTHER'S MAIDEN NAME
HAZEL TERRY | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
236-05-9787 | | 17. INFORMANT
ALICE TINSLEY WIFE | | ADDRESS
S/A |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) BRAIN ABSCESS (C) Temp Lobe
DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
4/9/66 | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
3 4/21/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
BRAIN Tumor. | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
- | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
- | | 21C. WHERE DID INJURY OCCUR?
- | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
- | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
4/19 1966 to 4/22 1966 | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/19 1966 to 4/22 1966, that (I) (we) last saw the deceased alive on 4/22 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Ivan L. Butler | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/22/66 | |
| 23C. PHYSICIAN'S NAME (Type)
IVAN L. BUTLER | | | | 23D. ADDRESS
M.D. UNIVERSITY HOSPITAL | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/24/66 | | 24C. NAME OF CEMETERY or CREMATORY
Stanford Cem. | | 24D. LOCATION (City, town, or county) (State)
Stanford W. Va. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | 25B. NAME OF REGISTRAR
R. E. E. F. F. | | 25C. FUNERAL DIRECTOR
Williams Funeral Home | | ADDRESS
319 N. Schroeder St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04145 | |
|--|---------|--|------------------|--|-----------------------------|
| BIRTH NO. | | 66 04145 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Stuart Brooks | | April 19, 1966 4:19 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

Provident Hospital
1514 Division Street
Baltimore, Maryland | | A. STATE | | B. COUNTY | |
| | | Maryland | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | Baltimore | | | |
| | | 1436 Argyle Avenue | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| Male | Negro | Unknown | 4-15-1890 | 76 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| None | | None | | Virginia | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Unknown | | Unknown | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | 218-30-6657 | | Fannie Clark 900 Madison Avenue | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO
<i>Acute Bronchopneumonia</i> | | | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 18, 1966 to April 19, 1966, that (I) (we) last saw the deceased alive on April 19, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Jose B. Corvera</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
April 20, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
Corvera | | 23D. ADDRESS
M.D. 1514 Division Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 4/25/66 | | Mt. Auburn Cemetery | |
| | | | | Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| APR 25 1966 | | <i>R. B. E. ...</i> | | Adolphus Halstead 1206 W North Ave | |

1436 Arkyle Avenue
Baltimore

4-12-1890

Virginia

Unknown

Fannie Clark

1214 Division Street
Baltimore, Maryland

Unknown

None

Male Negro

None

Unknown

April 18, 66

April 18, 66

April 18, 66

1214 Division Street

emery

Corvair

for a Corvair

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

ALVIN RUTH

2. DATE AND HOUR PRONOUNCED DEAD

April 19, 1966

4:23 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Franklin Square Hospital - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

310 N. Mount St.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

9. AGE (In years
past birthday)

34

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Morgan Richardson

14. MOTHER'S MAIDEN NAME

Evelyn

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
214-26-9588

17. INFORMANT

ADDRESS

Mrs Doroles E Ruth 220 N Stricker St

18. 381.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO fatty metamorphosis of the liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes-partial

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-20-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/25/66

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 25 1966

R. E. E. E. E.

Adolphus Halstead 1206 W North Ave

WALLEY FONGE

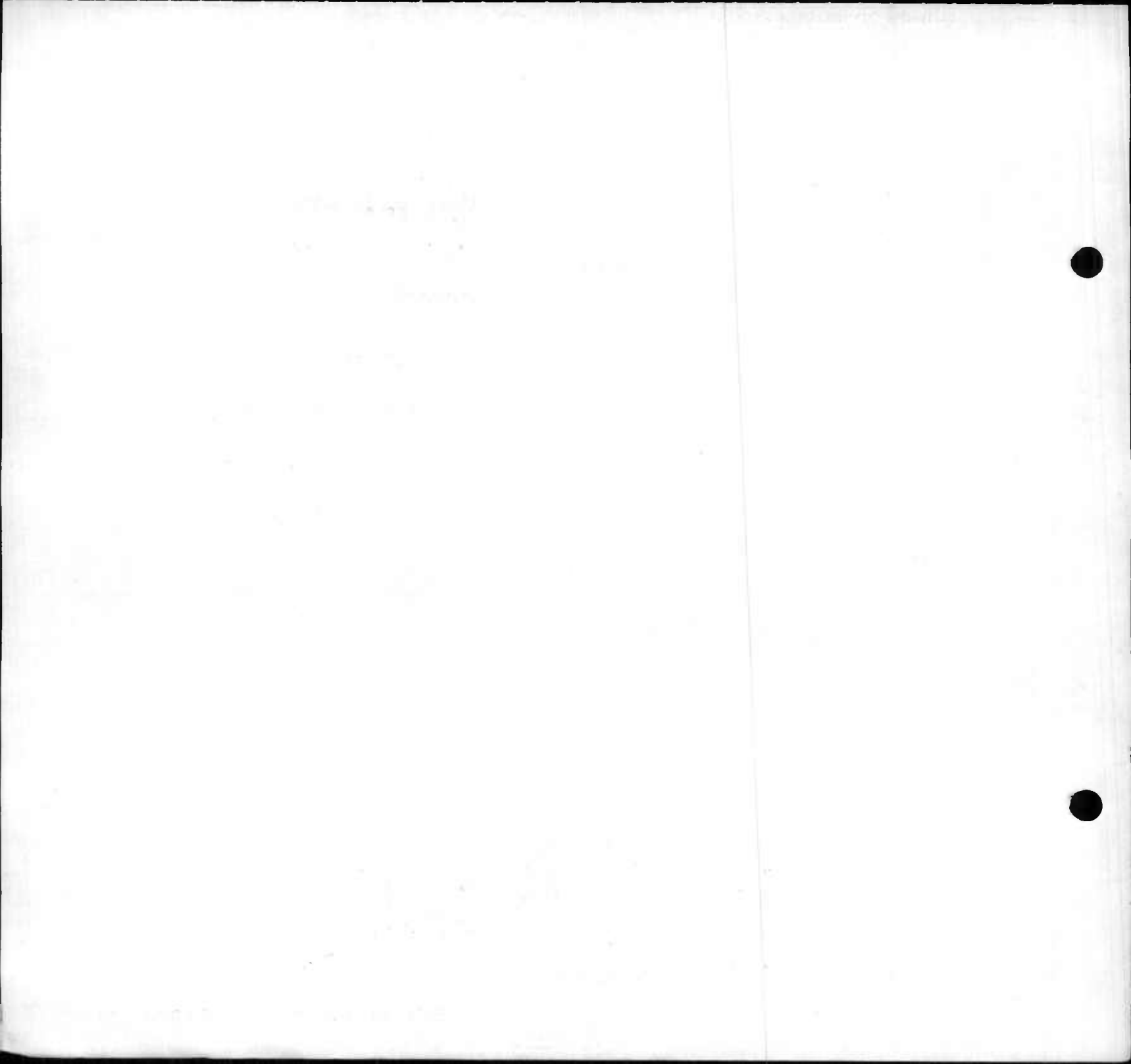
PHOTOGRAPH

1905

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04147 | |
|---|------------------|---|------------------------------------|---|---|
| BIRTH NO. 66 04147 | | CERTIFICATE OF DEATH | | Registered No. 66 04147 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Julia Pleasant (Vaughn)</i> | | 2. DATE AND HOUR OF DEATH
<i>4-20-66 8:15 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Md</i>
B. COUNTY <i>14-02</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Provident Hospital</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | | | |
| D. STREET ADDRESS (If rural, give location)
<i>1436 515 McMechen St</i> | | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>C</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Separated</i> | 8. DATE OF BIRTH
<i>4/15/90</i> | 9. AGE (In years last birthday)
<i>76</i> | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME
<i>Ellen Thomas</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<i>Mrs Jones 515 McMechen St</i> | |
| 18. <i>420.1 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <i>Myocardial Infarction</i>
DUE TO
(B) <i>Arterio Sclerotic Heart Disease</i>
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
<i>1 wk</i>
<i>Mo</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR?
III in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>4-20</i> 19 <i>65</i> to <i>4-20</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>4-20</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<i>Franklin Phillips</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>4/23/66</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>G. Franklin Phillips</i> | | 23D. ADDRESS
<i>558 McMechen St Balto 17 Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>4/25/66</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Mt Auburn Cemetry</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Baltimore Md</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>APR 25 1966</i> | | 25B. NAME OF REGISTRAR
<i>Adolphus Halstead</i> | |
| 25C. FUNERAL DIRECTOR
<i>Adolphus Halstead</i> | | ADDRESS
<i>1206 W North Ave</i> | | | |



66 04148

BALTIMORE CITY HEALTH DEPARTMENT

66 04148

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ESTER

LONG

2. DATE AND HOUR PRONOUNCED DEAD

April 22, 1966

10:21 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2930 Round Road

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Separated

8. DATE OF BIRTH

1/31/24

9. AGE (In years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

Edmonia Spruill

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Ida Black 910 Seagull Rd

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty liver cirrhosis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-22-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/27/66

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 25 1966

Adolphus Halstead 1206 W North

VALLEY FORGE

THE COMPANY

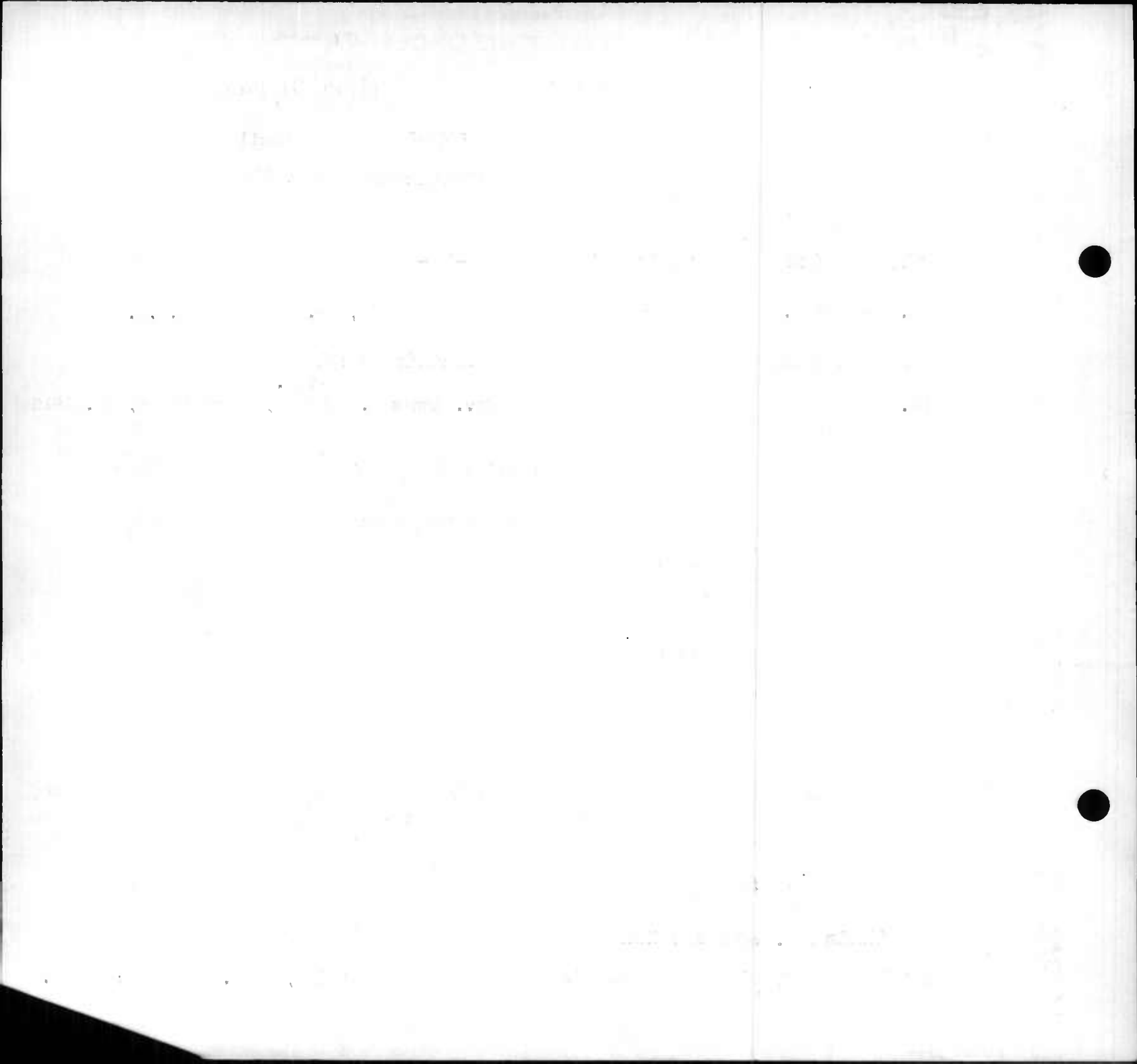
1884

1884

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

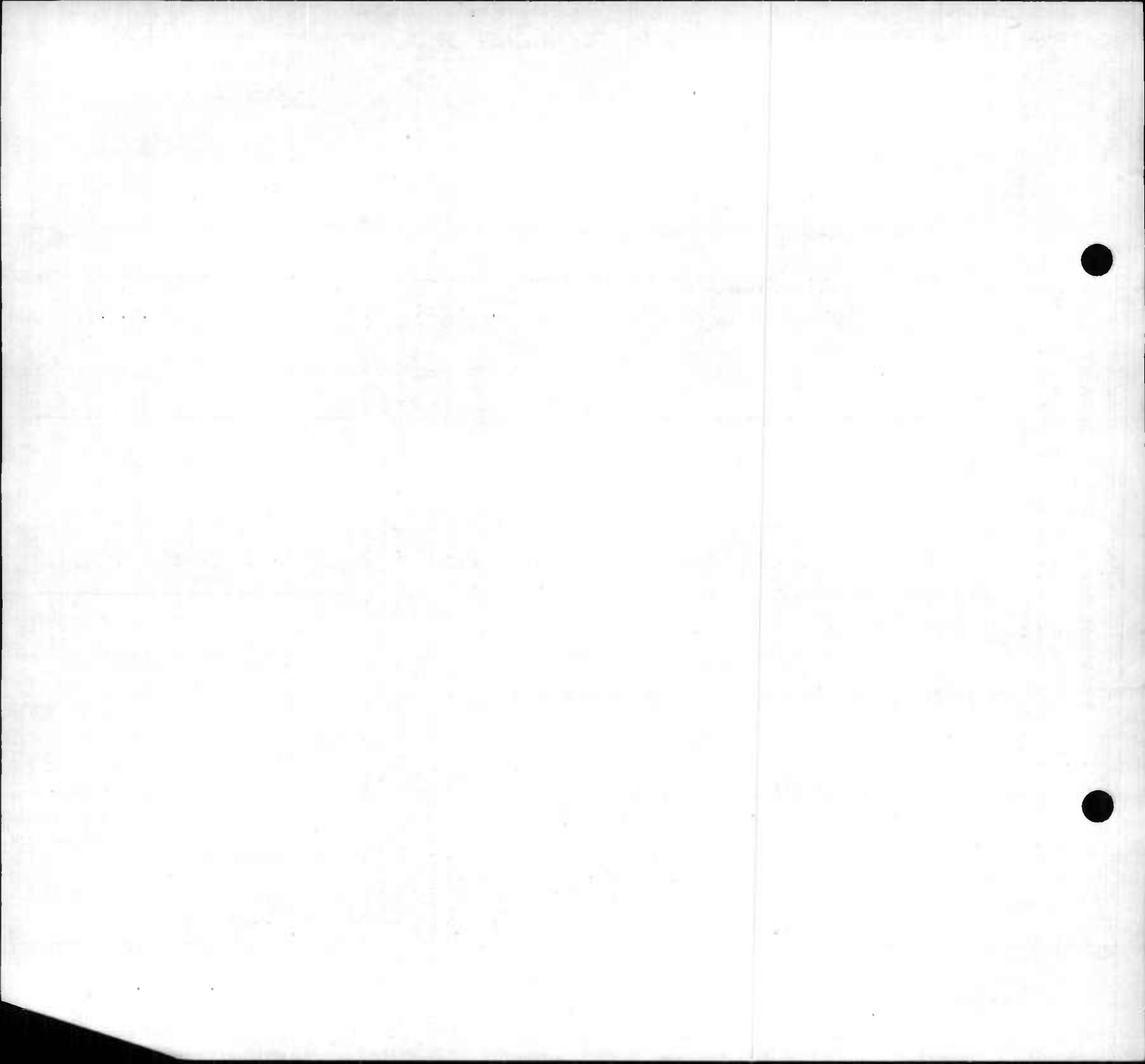
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|--|--|-------------------------|--|--|---|-------------------------------------|--|--|--|--|--|------------------------------------|--|--|
| BIRTH NO. 66 04149 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 04149 | | | | |
| 1. NAME OF DECEASED
(Type or Print) ALBERT REHFUSS | | | | | 2. DATE AND HOUR OF DEATH
April 21, 1966 | | | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
Johns Hopkins Hospital | | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY Cecil | | | | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township)
Earleville | | | | | 6. STREET ADDRESS (If rural, give location)
33 | | | | |
| 7. SEX
Male | | 8. RACE
White | | 9. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | | 10. DATE OF BIRTH
6-28-99 | | 11. AGE (In years
last birthday)
66 | | 12. If Under 1 Yr.
Months Days Hours Min. | | 13. If Under 24 Hrs.
Hours Min. | | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret. Machinist. | | | | | 15. KIND OF BUSINESS OR INDUSTRY
Factory | | | | | 16. BIRTHPLACE (State or foreign country)
Philadelphia, Pa. | | | | |
| 17. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | 18. FATHER'S NAME
John Rehfuß | | | | | 19. MOTHER'S MAIDEN NAME
Cecilia Becklee | | | | |
| 20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | | | | 21. SOCIAL SECURITY NO. | | | | | 22. INFORMANT
Wife. | | | | |
| 23. ADDRESS
Mrs. Agnes L. Rehfuß, Earleville, Md. 21919 | | | | | 24. CAUSE OF DEATH
Pulmonary embolus | | | | | 25. INTERVAL BETWEEN ONSET AND DEATH
mins | | | | |
| 26. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Antecedent causes | | | | | 27. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | 28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Post Necrotic cirrhosis, Esophageal varices | | | | |
| 29. DATE OF OPERATION
2 | | | | | 30. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 31. AUTOPSY? (Yes or No)
Yes | | | | |
| 32. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 33. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 34. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 35. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | | | | 36. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 37. HOW DID INJURY OCCUR? | | | | |
| 38. I certify that (this hospital) attended the deceased from 3/31 19 66 to 4/21 19 66 , that (we) lost saw the deceased alive on 4/21 19 66 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | | | | 39. SIGNATURE
W. H. Spencer III | | | | |
| 40. PHYSICIAN'S NAME (Type)
William H. Spencer III | | | | | 41. ADDRESS
Johns Hopkins Hospital | | | | | 42. DATE SIGNED
4/21/66 | | | | |
| 43. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | | 44. DATE
4/25/66 | | | | | 45. NAME OF CEMETERY OR CREMATORY
Old Bohemia Cemetery | | | | |
| 46. LOCATION
Warwick, Rural. Cecil Co; | | | | | 47. DATE REC'D BY HEALTH DEPT. | | | | | 48. NAME OF REGISTRAR
Edw. E. Taylor | | | | |
| 49. FUNERAL DIRECTOR
Edward Sullowz Miller | | | | | 50. APR 25 1966 | | | | | 51. VS 150-REV. 1/7/65 | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

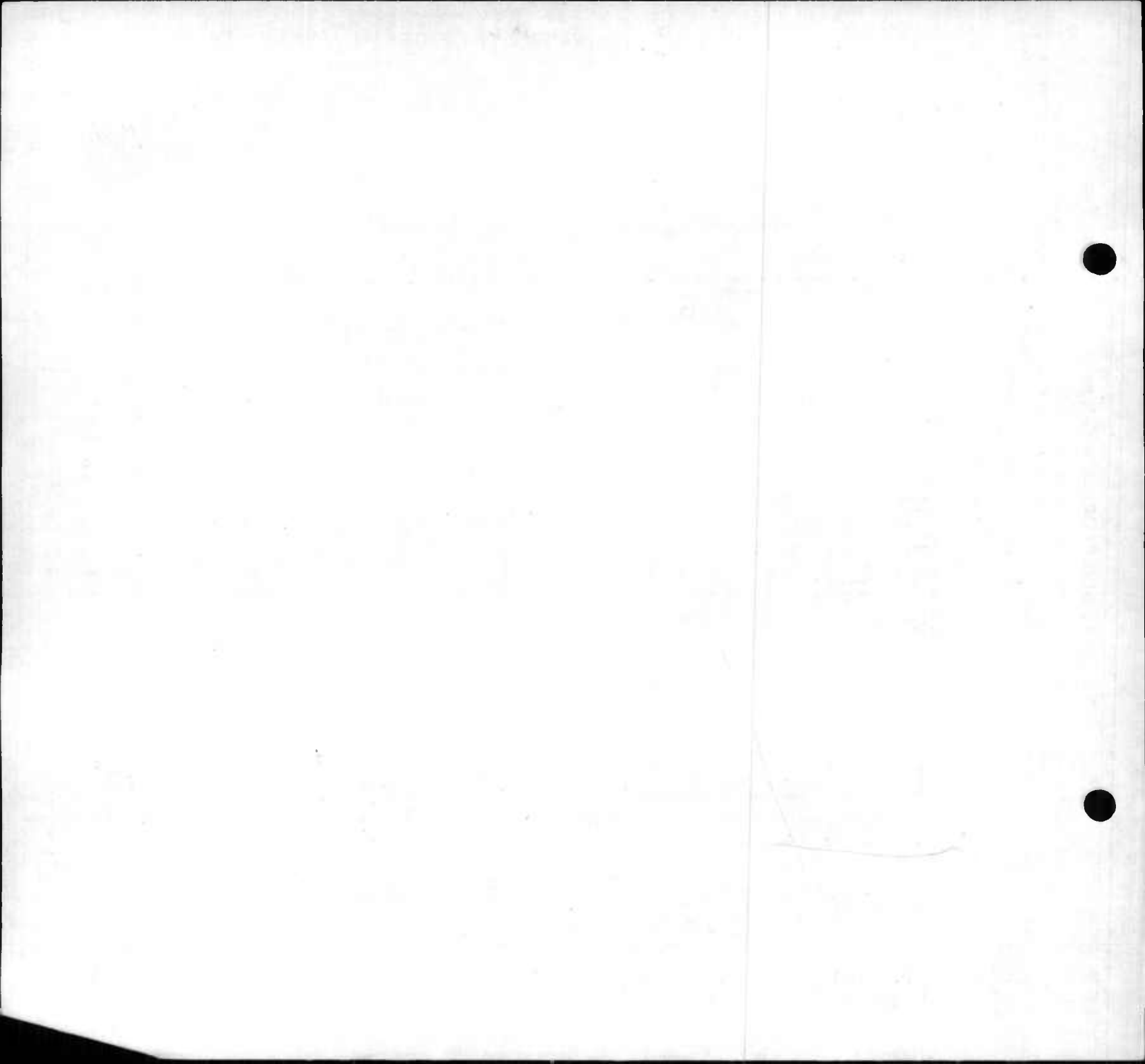
| BIRTH NO. 66 04150 | | | | CITY HEALTH DEPARTMENT | | Registered No. 66 04150 | |
|--|--|--|--|---|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Nelson W. Gutermuth | | | | 2. DATE AND HOUR OF DEATH
4-22-1966 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
5934 Kavon Avenue #6 | | | | A. STATE Md. B. COUNTY 26-01 | | | |
| 5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | | | 8. DATE OF BIRTH 4-3-1904 9. AGE (In years lost birthday) 62 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier | | | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | | |
| 10B. KIND OF BUSINESS OR INDUSTRY National Brewing Co. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Charles Gutermuth | | | | 14. MOTHER'S MAIDEN NAME Mathilda Harman | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 216-07-3086 | | | |
| 17. INFORMANT Mrs Stella Gutermuth 5934 Kavon Avenue | | | | ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
159X1
Circulatory failure 2 days
colitis 3 yrs
probable g. malignancy | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 20 19 66 to April 22 19 66, that (I) (we) last saw the deceased alive on April 22 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Richard R. Rigler M.D. | | | | 23B. DATE SIGNED 4-22-66 | | | |
| 23C. PHYSICIAN'S NAME (Type) RICHARD R. RIGLER | | | | 23D. ADDRESS M.D. 1 W. OVERLEA AVE. CITY 6 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4-25-1966 | | 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 25 1966 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR Lassahn Funeral Home 7401 B | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 04151 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 04151 | |
|---|----------------------|--|---|--|---|---|---|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) Hudzik, Benjamin K. | | 2. DATE AND HOUR OF DEATH
4-21-66 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MD.
B. COUNTY Balto | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Maryland Gen. Hospital
Baltimore, MD | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | D. STREET ADDRESS (If rural, give location)
8120 Woodhaven Rd. | | | |
| 5. SEX
Male | 6. RACE
W. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
11-16-88 | 9. AGE (In years last birthday)
77 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY
Baker | | 11. BIRTHPLACE (State or foreign country)
Germany | | 12. CITIZEN OF WHAT COUNTRY?
US | | |
| 13. FATHER'S NAME
John Hudzik | | | | 14. MOTHER'S MAIDEN NAME
Catherine ? | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
219-10-4494 | | 17. INFORMANT
Albert R. Herwig | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Bleeding gastric ulcer | | | | CAUSE OF DEATH
(A) DUE TO
Bleeding gastric ulcer
(B) DUE TO
Heart failure & pneumonia
(C) _____ | | ADDRESS
1231 Spring Ave
INTERVAL BETWEEN ONSET AND DEATH
from 4-17-66 to 4-21-66 | | | |
| 19A. DATE OF OPERATION
4-19-66 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Reversion | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
No | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 17 19 66 to April 21 19 66 , that (I) (we) last saw the deceased alive on April 21 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Joseph Moon | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4-21-1966 | | | |
| 23C. PHYSICIAN'S NAME (Type)
YOUNTSIK MOON | | | | 23D. ADDRESS
8272 Linden Ave. Baltimore, MD | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-25-66 | | 24C. NAME OF CEMETERY or CREMATORY
Holy Rosary Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | | | 25B. NAME OF REGISTRAR
Robert E. Schickel | | 25C. FUNERAL DIRECTOR
Crach Funeral Home - Rosedale | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 04152</u> | |
|--|---------------------|--|--|--|---|
| 66 04152 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) <u>Reddish, Ruth L. R.</u> | | | | <u>4-21-66</u> <u>8:15 P</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>South Baltimore General Hospital</u> | | A. STATE
<u>Md</u> | | B. COUNTY
<u>2404</u> | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>105 E Fort Ave</u> | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
<u>WIDOWED, DIVORCED (specify)</u>
<u>Widow</u> | 8. DATE OF BIRTH
<u>Dec. 28, 87</u> | 9. AGE (In years last birthday)
<u>78</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housework</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Balto. Md</u> | |
| 13. FATHER'S NAME
<u>John Bradley</u> | | 14. MOTHER'S MAIDEN NAME
<u>Clara Petty</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U S A</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Mr. Vernon Reddish</u> | |
| | | | | ADDRESS
<u>105 E. Fort Ave</u> | |
| 18. <u>4-22-66</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>CEREBRAL VASCULAR ACCIDENT</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 HRS</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO
<u>PHENOLIC LOBB</u> | | <u>UNKNOWN</u> | |
| | | (B) DUE TO
<u>ASCVD</u> | | <u>25+ yrs</u> | |
| | | (C) <u>ASCVD</u> | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>DEHYDRATION, MALNUTRITION</u> | | <u>UNKNOWN</u> | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| <u>0</u> | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/21/66</u> 19 <u>66</u> to <u>4/21/66</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/21/66</u> 19 <u>66</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>E. A. Hoffman MD</u> | | | | 23B. DATE SIGNED
<u>4-21-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
M.D. | |
| | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4 25 66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Baltimore</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State)
<u>Balto. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 25 1966</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Gentry, MD</u> | | 25C. FUNERAL DIRECTOR
<u>Mc Cully</u> | |
| | | | | ADDRESS
<u>130 E. Fort Ave</u> | |

2nd Baltimore General Hospital and 2nd Artillery

CERTIFICATE OF DISCHARGE

PROBATION - 1864

A2CUD

DISCHARGED FROM SERVICE

2nd Artillery

1864

1864

1864

1864

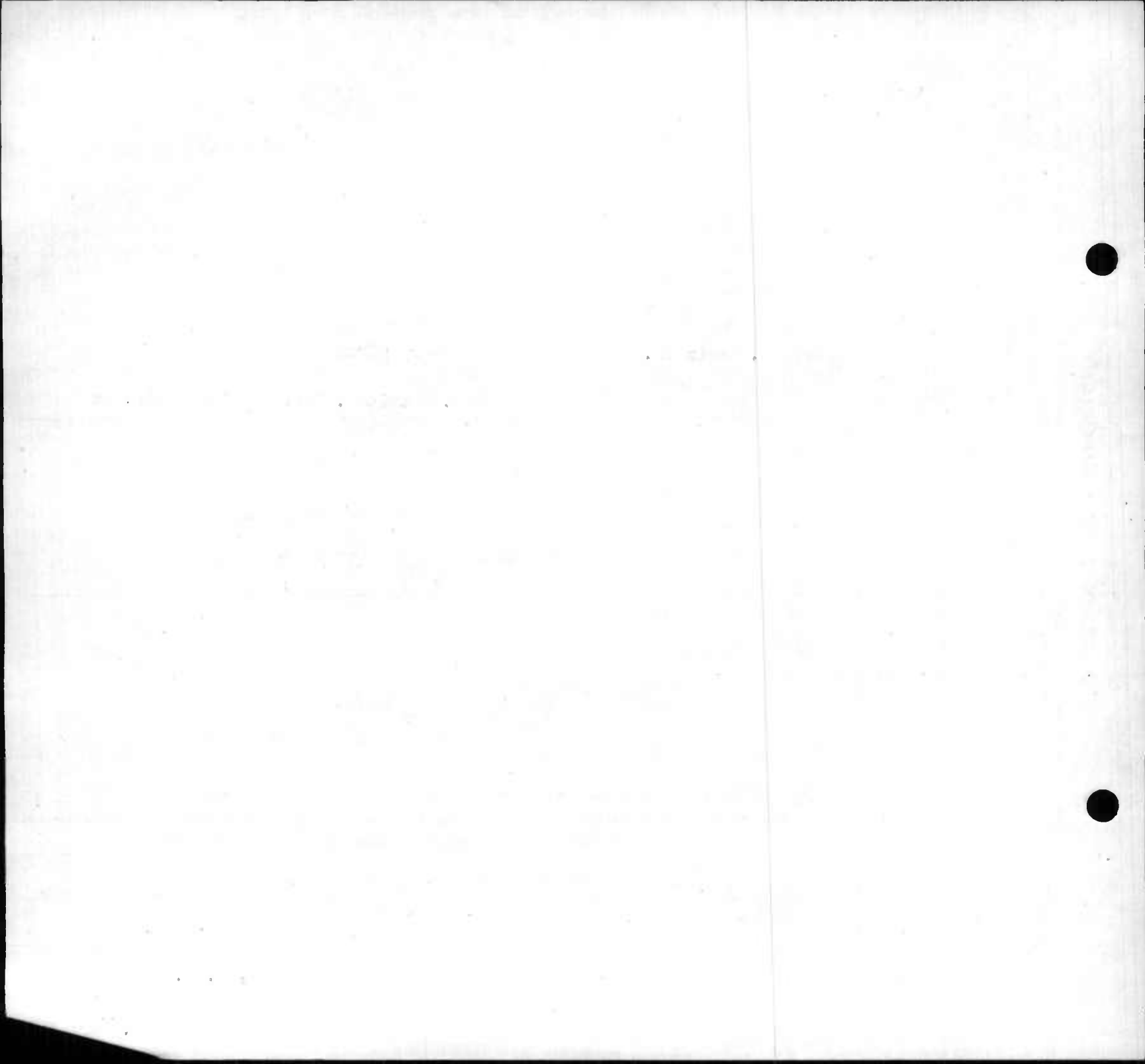
1

4-5-4

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04153 | |
|---|--|---|--|---|--|
| 66 04153 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| HOWARD W. LANTZ | | FULL NAME OF HOSPITAL OR INSTITUTION
36 FRANKLIN SQUARE HOSPITAL | | A. STATE
MD
B. COUNTY
24-03 | |
| 5. SEX
M | | 6. RACE
W | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
M | | 8. DATE OF BIRTH
3-15-15 | | 9. AGE (In years last birthday)
50 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Storeman | | 10B. KIND OF BUSINESS OR INDUSTRY
Railroad | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE MD | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Howard W. Lantz Sr. | | 14. MOTHER'S MAIDEN NAME
Mary Hirsch | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
214 01 8748 | | 17. INFORMANT
Mrs. Lottie M. Lantz 1225 William St | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
542.1 I
Septic shock with renal shutdown | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
4-20-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
PERFORATED MARGINAL ULCER | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 19 1966 to April 21 1966, that (I) (we) last saw the deceased alive on April 21 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Wilfredo M. Mediano | | | | 23B. DATE SIGNED
April 21, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
WILFREDO M-MEDIANO | | 23D. ADDRESS
FRANKLIN SQUARE HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4 25 66 | | 24C. NAME OF CEMETERY or CREMATORY
Glen Haven | |
| 24D. LOCATION
Glen Burnie, A. A. Co Md | | 24E. STATE
(City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | 25B. NAME OF REGISTRAR
Robert E. Jones | | 25C. FUNERAL DIRECTOR
Mc Gully 130 E. ... | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO. 66-04154
66-28599

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CARLOS J. COOKSON

2. DATE AND HOUR PRONOUNCED DEAD

April 22, 1966 10:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1304 Williams Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Nov. 19, 1965

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

5 3

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Balto. Md

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Unknown Jas. Jininez

14. MOTHER'S MAIDEN NAME

Joyce A. Cookson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Wm. A. Cookson

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Interstitial pneumonitis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-22-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4 23 66

23C. NAME of CEMETERY or CREMATORY

Cedar Hill

23D. LOCATION

(City, town, or county)

(State)

Brooklyn, A. A. Co. Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 25 1966

24B. NAME OF REGISTRAR

R. E. Petty, M.D.

24C. FUNERAL DIRECTOR

Mc Cully

ADDRESS

130 E. Fort Ave

WALTER P. FORGE

PRO CONTEST

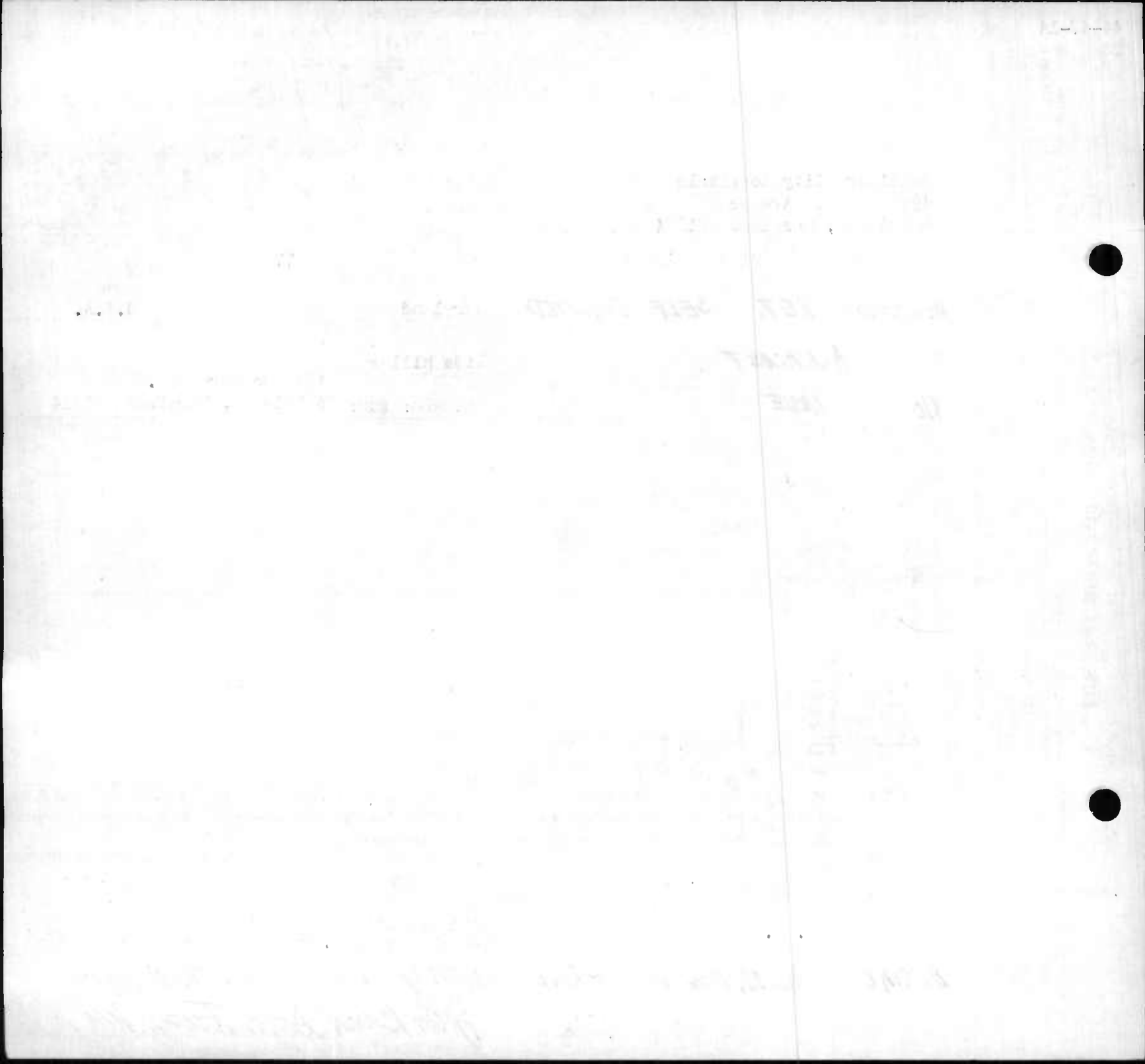
44-47-14

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| Registered No. 44-47-14 | | | | | | | | | |
| <div> <div> A-652 00 04155 </div> <div> BIRTH NO. </div> </div> <div> <div> M.E. CASE NO. </div> <div> 1. NAME OF DECEASED
(Type or Print) </div> </div> <div> <div> 2. DATE AND HOUR OF DEATH </div> <div> 4/19/66 </div> </div> | | | | | | | | | |
| <div> <div> 3. PLACE OF DEATH IN BALTIMORE, MARYLAND </div> <div> FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) </div> </div> <div> <div> 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) </div> <div> A. STATE
MD </div> </div> | | | | | | | | | |
| <div> <div> 5. SEX
Male </div> <div> 6. RACE
White </div> </div> <div> <div> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Divorced </div> <div> 8. DATE OF BIRTH
4/17/89 </div> </div> | | | | | | | | | |
| <div> <div> 9. AGE (In years last birthday)
77 </div> <div> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MECHANIC- RET. </div> </div> <div> <div> 11. BIRTHPLACE (State or foreign country)
Maryland </div> <div> 12. CITIZEN OF WHAT COUNTRY?
U.S.A. </div> </div> | | | | | | | | | |
| <div> <div> 13. FATHER'S NAME
Joshus ARMACOST </div> <div> 14. MOTHER'S MAIDEN NAME
Lida Miller </div> </div> <div> <div> 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No NONE </div> <div> 16. SOCIAL SECURITY NO. </div> </div> | | | | | | | | | |
| <div> <div> 17. INFORMANT
4940 Eastern Ave. ADDRESS
RECORDS: BCH: Baltimore, Maryland 21224 </div> <div> 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) CA of the Throat
(B) DUE TO
(C) </div> </div> <div> <div> 19. DATE OF OPERATION
2 </div> <div> 20. AUTOPSY? (Yes or No)
YES </div> </div> | | | | | | | | | |
| <div> <div> 21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
21A. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) </div> <div> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) </div> </div> <div> <div> 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) </div> <div> 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> </div> </div> | | | | | | | | | |
| <div> <div> 22. I certify that (I) (this hospital) attended the deceased from 10/19 1965 to 4/19 1966, that (I) (we) last saw the deceased alive on 4/19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. </div> <div> 23A. SIGNATURE
D.E. Gaasterland </div> </div> <div> <div> 23B. DATE SIGNED
4/19/66 </div> <div> 23C. PHYSICIAN'S NAME (Type)
D. E. Gaasterland </div> </div> | | | | | | | | | |
| <div> <div> 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL </div> <div> 24B. DATE
APR 22 1966 </div> </div> <div> <div> 24C. NAME of CEMETERY or CREMATORY
PINE GROVE CEMETERY </div> <div> 24D. LOCATION (City, town, or county) (State)
PAXVILLE, BALTO. CO., MD. </div> </div> | | | | | | | | | |
| <div> <div> 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 </div> <div> 25B. NAME OF REGISTRAR
John R. Jones, Towson, Md. </div> </div> <div> <div> 25C. FUNERAL DIRECTOR
John R. Jones, Towson, Md. </div> <div> 25D. ADDRESS
 </div> </div> | | | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04156 | |
|---|------------------|---|------------------------------------|--|--|
| BIRTH NO. 66 04156 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Butler, John T. | | 2. DATE AND HOUR OF DEATH
Apr 20, 1966 3 34 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Balto | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 36
D. STREET ADDRESS (If rural, give location)
115 Sipple Ave #36 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
38 University Hospital | | (If not in hospital or institution, give street address or location) | | 9. AGE (In years last birthday) 43 | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
1/17/23 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Service mechanic | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY
Charles Novelties | | 11. BIRTHPLACE (State or foreign country)
Md | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Peter Butler | | 14. MOTHER'S MAIDEN NAME
Emma Novatuy | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes WW II | | 16. SOCIAL SECURITY NO.
216-12-8700 | | 17. INFORMANT
Patricia | |
| 18. 204.31 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) Acute Myelogenous Leukemia | | 5 months | |
| ANTECEDENT CAUSES | | (B) Intake | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from March 25 1966 to April 20 1966 , that (I) (we) last saw the deceased alive on April 20 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Harold C. Standford | | | | 23B. DATE SIGNED
4/20/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/25/66 | | 24C. NAME OF CEMETERY or CREMATORY
Gardens of Faith Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Jenkins | | 25C. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc. | | | |
| 25D. ADDRESS
3331 Brehms Lane #13 | | | | | |

yes W II

Peter

Service mechanic Charles Douglas

M W

married

11/2/23 W 3

Common Monday

Robert

Acute myocardial infarction

yes

Handwritten signature

April 20

March 22

22

April 20

4/20/23

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

JESSE BARNSTRICKER

2. DATE AND HOUR PRONOUNCED DEAD

April 19, 1966

9:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3904 Dudley Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

March 29, 1915

9. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Drug Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Calvert Drug Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

214-05-5639

17. INFORMANT

(nee Warehime)

ADDRESS

Hilda Barnstricker, wife, above

18.

410X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Rheumatic heart disease with mitral
DUE TO insufficiency and calcification
and multiple myocardial scars

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-19-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/22/66

23C. NAME of CEMETERY or CREMATORY

Parkwood Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

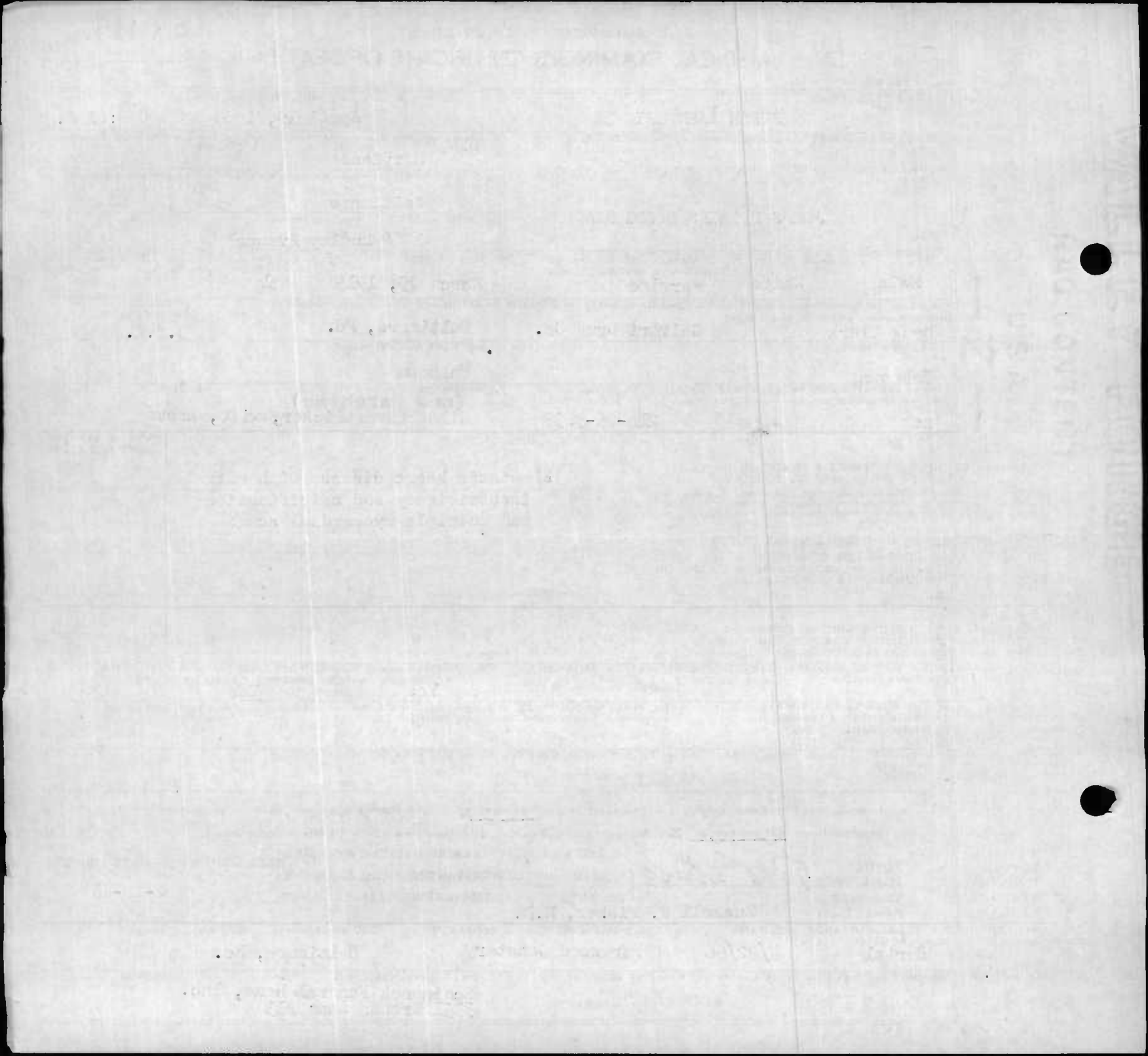
24C. FUNERAL DIRECTOR

ADDRESS

APR 25 1966

Robert E. Fisher, M.D.

Schimunek Funeral Home, Inc.
3331 Brehms Lane #13



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REGISTERED NO. 66 04158 | |
|--|--|--|---|--|--|
| F. 420 66 04158 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | ROSE FLOCKS | | APRIL 21, 1966 4:05 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

3532 WHITE CHAPEL ROAD | | | A. STATE
MARYLAND
B. COUNTY
BALTIMORE | | |
| 5. SEX
FEMALE | | | 6. RACE
WHITE | | |
| 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | | | 8. DATE OF BIRTH
87 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | |
| HOUSEWIFE | | | RUSSIA | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| AT HOME | | | USA | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| JOSEPH BLACKMAN | | | VELLA ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| NO | | | NO | | |
| 17. INFORMANT | | | ADDRESS | | |
| MRS. AARON FREEMAN | | | 3532 WHITE CHAPEL ROAD | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| ANTECEDENT CAUSES | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | 103+
33 | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 01963 | | ca of colon | | no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1936 to 4/21/66, that (I) (we) last saw the deceased alive on 4/20/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| DR. M. S. SHILING | | | | APRIL 21, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| DR. M. S. SHILING | | | | 2500 EUTAW PLACE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| BURIAL | | 4/24/66 | | ANSHE EMUNAH (AITZ CHAIM) | |
| 24D. LOCATION | | 24E. LOCATION | | 24F. LOCATION | |
| BALTIMORE, MARYLAND | | BALTIMORE, MARYLAND | | BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| APR 25 1966 | | Robert E. Shilling | | SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | |

THE UNIVERSITY OF

THE UNIVERSITY OF

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 04159 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 4159 | |
|---|-------------------------|---|---|--|---|
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED
(Type or Print) NATHAN MILLER | | |
| 2. DATE AND HOUR OF DEATH
APRIL 21 1966 11:08A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 603 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
CHURCH HOME HOSPITAL | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location)
2204 E. BALTIMORE ST | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
SINGLE | 8. DATE OF BIRTH | 9. AGE (In years last birthday)
72 | 10. Under 1 Yr. Months Days
11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
TAILOR | | 10B. KIND OF BUSINESS OR INDUSTRY
RETIRED | | 11. BIRTHPLACE (State or foreign country)
RUSSIA | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
HYMAN LOUIS MILLER | | 14. MOTHER'S MAIDEN NAME
LEAH SNYDER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
CHART + SISTER RAE MILLER | |
| 18. CAUSE OF DEATH
400.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ACUTE PULMONARY EDEMA
INTERVAL BETWEEN ONSET AND DEATH
HYSTEROSCLEROTIC HEART DISEASE | | | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 21 1966 to APRIL 21 1966 , that (I) (we) last saw the deceased alive on APRIL 21 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Dr. C. Tolentino M.D. | | | | 23B. DATE SIGNED
4/21/66 | |
| 23C. PHYSICIAN'S NAME (Type)
MARINO A. TOLENTINO M.D. | | | | 23D. ADDRESS
CHURCH HOME HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/22/66 | | 24C. NAME OF CEMETERY OR CREMATORY
BETH JACOB VECAIR | |
| 24D. LOCATION (City, town, or county) (State)
ROSEDALE, MARYLAND | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | 25B. NAME OF REGISTRAR
Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | |

APRIL 21 1954

CHARLES HOME HOSPITAL
204 E BALTIMORE ST
BALTIMORE
MICHIGAN

THOMAS W
RETIRED
HUMAN LOUIS MILLER
LEAH SNIDER
GREAT + SISTER

WHITE PULMONARY STAIN
METABOLIC HEART DISEASE

APRIL 21 1954

MR. C. J. L. W.
MR. A. J. L. W.
APRIL 21 1954

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04160 | |
|---|---|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 66 04160 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) Dora Joffe | | | 2. DATE AND HOUR OF DEATH
4/20/66 1 7 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
44 Union Memorial Hosp | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY 1301
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2519 Brookfield AVE. BROOKFIELD | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
SINGLE | 8. DATE OF BIRTH
12/27/97 | 9. AGE (in years last birthday)
68 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
retired | | 10B. KIND OF BUSINESS OR INDUSTRY
SECRETARY | 11. BIRTHPLACE (State or foreign country)
HAGERSTOWN Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Max Joffe | | | 14. MOTHER'S MAIDEN NAME
Dadie Joffe (correct) | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS
MRS. LENA COHEN 901 LAKE DRIVE APT C2 #17 | | |
| 18. 422.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) DUE TO ASCVD
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
6 mos |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/19 19 66 to 4/20 19 66 , that (I) (we) last saw the deceased alive on 4/20 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Hudson Fesche | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/20/66 |
| 23C. PHYSICIAN'S NAME (Typed)
HUDSON FESCHE | | | 23D. ADDRESS
UNION MEMORIAL HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/22/66 | | 24C. NAME OF CEMETERY or CREMATORY
HEBREW FRIENDSHIP | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | 25B. NAME OF REGISTRAR
R. E. E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
SOL LEVINSON & BROS. INC. 6010 REisterstown rd | |



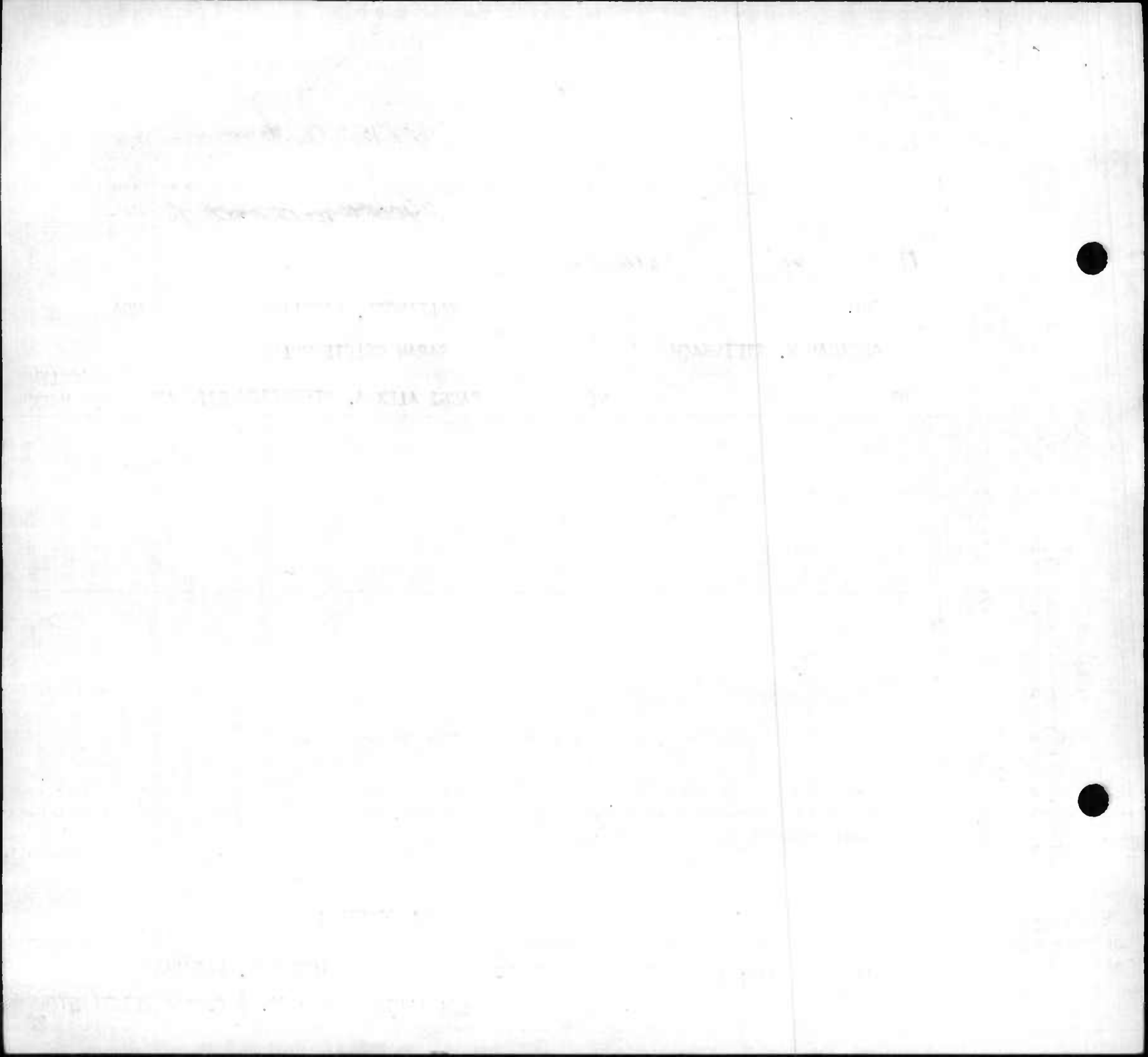
UNITED STATES OF AMERICA

1950

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 66 04161 | | 66 04161 | |
|---|---------|--|------------------|--|----------------------------|--|--|
| CERTIFICATE OF DEATH | | | | Registered No. | | | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | DR. Reuben Steinbach | | 4/20/66 8 ³⁰ a. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 42 Sinai Hospital | | | | 2 Maryland | | | |
| | | | | C. CITY OR TOWN (If inside city limits, write RURAL and give township) | | | |
| | | | | Baltimore 15-10 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 3900 Chatham Road | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | | |
| Male | White | SINGLE | 1-24-97 | 69 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| PHD | | | | BALTIMORE, MARYLAND | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| ABRAHAM W. STEINBACH | | | | SARAH GOLDIE WOLF | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| NO | | NO | | RABBI ALEX A. STEINBACH | | 2310 AVE R NEW YORK BROOKLYN | |
| 18. 350.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) Acute M.I. (Myocardial infarct) | | 40 min | |
| | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| 19B. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | peritonitis due to perforated appendix | | 3 days | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 3 4/18/66 | | as above | | YES | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/18/66 to 4/20/66, that (I) (we) last saw the deceased alive on 4/20/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| [Signature] | | | | | | 4/20/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| | | | | M.D. SINAI HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 4/21/66 | | GREATER BALTIMORE LODGE | | BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| APR 25 1966 | | [Signature] | | SOL LEVINSON & BROS. INC. | | 6010 REISTERSTOWN RD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 04162 | |
|---|-------------------|--|---------------------------|---|---|---|----------------------------------|
| BIRTH NO. 66 04162 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MAUD Copeland | | 2. DATE AND HOUR OF DEATH 24 APR 66 7:50 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY OF MARYLAND HOSPITAL | | A. STATE Maryland | | B. COUNTY 20-05 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| D. STREET ADDRESS (If rural, give location) 2652 Dalaney Street | | E. CITY OR TOWN (If rural, give location) Dalany | | F. STATE Maryland | | G. COUNTY 20-05 | |
| 5. SEX F | 6. RACE Caucasian | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 10/14/78 | 9. AGE (In years last birthday) 87 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Philip D. Copeland | | 14. MOTHER'S MAIDEN NAME Elizabeth Weddel | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT MRS. Syresch. GLEN BURNIE. Md. | | 18. 450.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) DUE TO Atherosclerosis Generalized (B) DUE TO Malnutrition Dehydration (C) suspected Myocardial Infarction | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 4/27/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 4/23/66 to 4/24/66, that (I) (we) last saw the deceased alive on 4/24/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Michael B. Flynn M.D. | |
| 23B. DATE SIGNED 4/24/66 | | 23C. PHYSICIAN'S NAME (Type) MICHAEL B. FLYNN M.D. | | 23D. ADDRESS Univ - Hosp | | 23E. PHYSICIAN'S ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL BURIAL | | 24B. DATE 4-27-66 | | 24C. NAME OF CEMETERY OR CREMATORY MT. OLIVET | | 24D. LOCATION (City, town, or county) BALTIMORE, Md | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 25 1966 | | 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR Geo. L. Sch... 6600 ... | | 25D. ADDRESS ... | |

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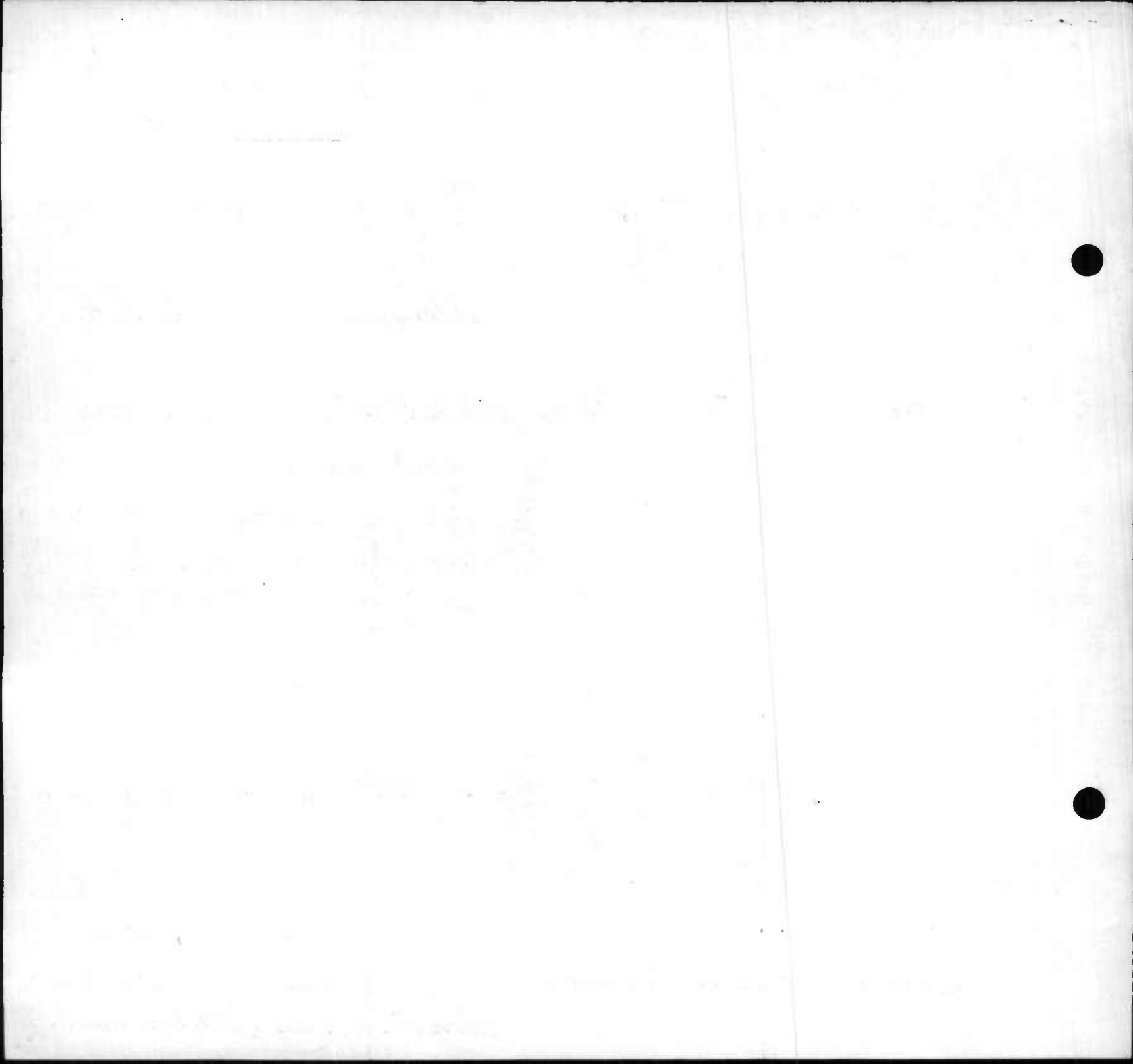
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| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--|--|--|---|---|--|-------------------------------------|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 66 04163 | | | | |
| G. 125
M.E. CASE NO. 66 04163
1. NAME OF DECEASED
(Type or Print) THERA GOOD A. GIBSON | | | | | 2. DATE AND HOUR OF DEATH
4-19-66 8:35 PM | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
31 BALTO CITY HOSP
4940 Eastern Avenue, Baltimore, Maryland | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY BALTO
C. CITY OR TOWN BALTO
D. STREET ADDRESS (If rural, give location)
2118 E. BALTIMORE ST 21231 | | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) ? | | 8. DATE OF BIRTH Unknown | | 9. AGE (In years last birthday) 91 (?) | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ? | | 10B. KIND OF BUSINESS OR INDUSTRY ? | | 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME ? | | | | 14. MOTHER'S MAIDEN NAME ? | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT MED. CHART
Records: BCH-4940 Eastern Avenue 21224 | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Hypotension
INTERVAL BETWEEN ONSET AND DEATH 14 hours
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Hyperglycemic Synd
DAY 5
DIABETES MELLITUS
? | | | | | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
II | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (H) (this hospital) attended the deceased from 4-19 (12:45) 1966 to 9:35 4-19 1966 that (H) (we) last saw the deceased alive on 4-19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE J.E. Randall M.D. | | | | 23B. DATE SIGNED 4-19-66 | | | | 23C. PHYSICIAN'S NAME (Type) J.E. Randall | |
| 23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland | | | | 23E. FUNERAL DIRECTOR Anne Arundel Co., Md.
521 Loch Raven Blvd. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4/23/66 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven | | 24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 25 1966 | | 25B. NAME OF REGISTRAR R. E. F. J. J. J. | | 25C. FUNERAL DIRECTOR 521 Loch Raven Blvd. | | | | | |



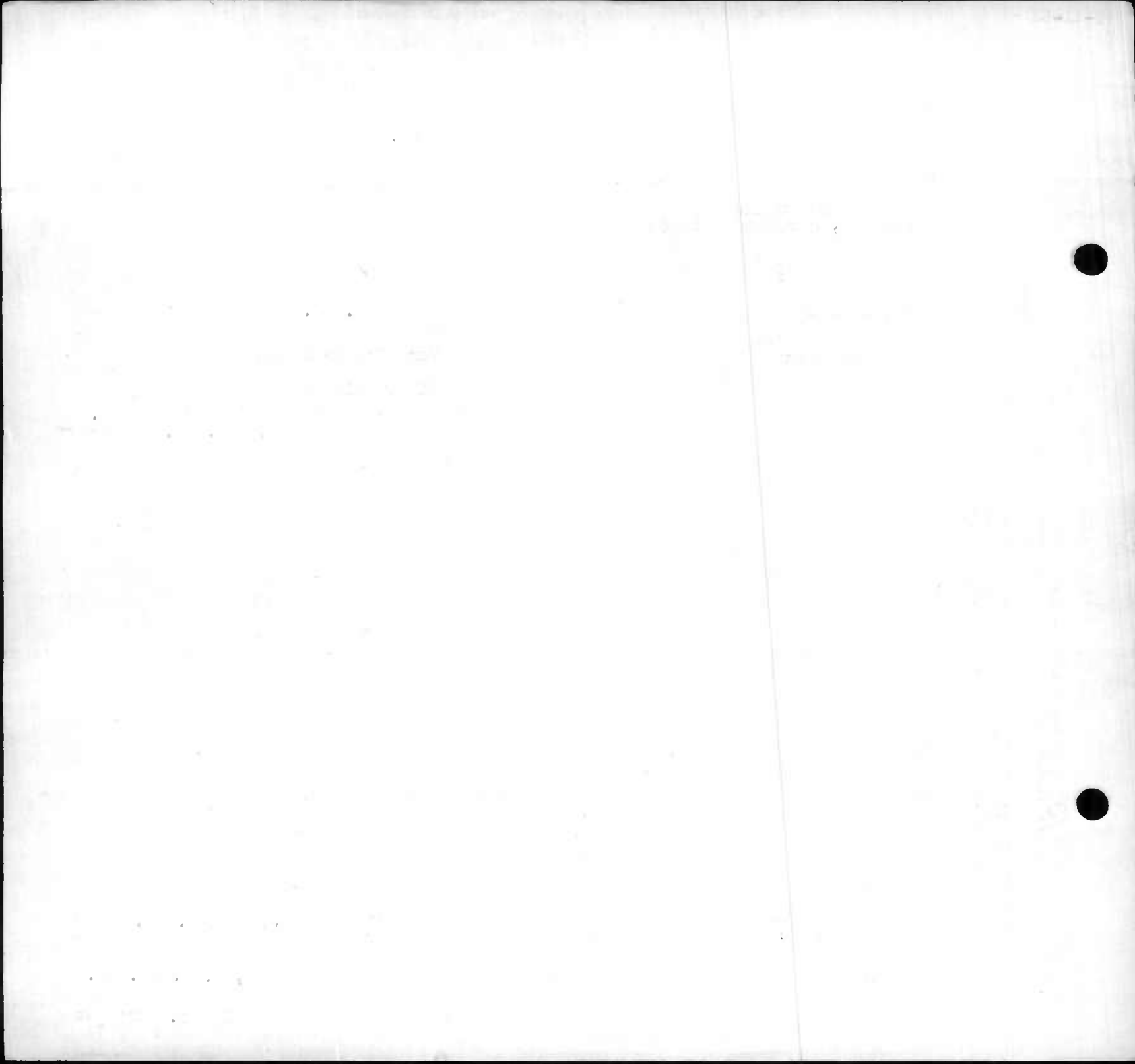
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04164 | |
|--|-------------------------|--|------------------------------------|--|---|
| BIRTH NO. 66 04164 | | CERTIFICATE OF DEATH | | Registered No. 66 04164 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) JOHN JACKSON | | 2. DATE AND HOUR OF DEATH
4-19-66 2:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MARYLAND B. COUNTY 11-83 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION
BALTIMORE CITY HOSPITAL
4940 Eastern Avenue
Baltimore, Maryland 21224 | | D. STREET ADDRESS (If rural, give location)
885 N. HOWARD | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
NEVER MARRIED? | 8. DATE OF BIRTH
10-4-16 | 9. AGE (In years last birthday)
49 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Supervisor | | 10B. KIND OF BUSINESS OR INDUSTRY
Building | | 11. BIRTHPLACE (State or foreign country)
Balto. Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Unknown Adams | | 14. MOTHER'S MAIDEN NAME
Veronica Paplauskas | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNKNOWN | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Baltimore City Hospitals
HOSPITAL CHART 4940 Eastern Ave.
Balto. Md. | |
| 18. 956.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
PNEUMONIA
(A) DUE TO
AMYOTROPHIC LATERAL SCLEROSIS
(B) DUE TO
(C) _____ | | CAUSE OF DEATH
Balto. Md. | | INTERVAL BETWEEN ONSET AND DEATH
1 wk.
8 mos | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 11-5-66 19 65 to 4-19 19 66 , that (1) (we) last saw the deceased alive on 4-19 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
William McLean, Jr. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4-19-66 | |
| 23C. PHYSICIAN'S NAME (Type)
WILLIAM T. McLEAN, JR. | | M.D. 23D. ADDRESS
4940 Eastern Ave. - Balto. Md. 21224
BALTIMORE CITY HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4 22 66 | | 24C. NAME OF CEMETERY or CREMATORY
Glen Haven | |
| 24D. LOCATION (City, town, or county) (State)
Glen Burnie, A. A. Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR
Mc Cully | | ADDRESS
130 E. Fort Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

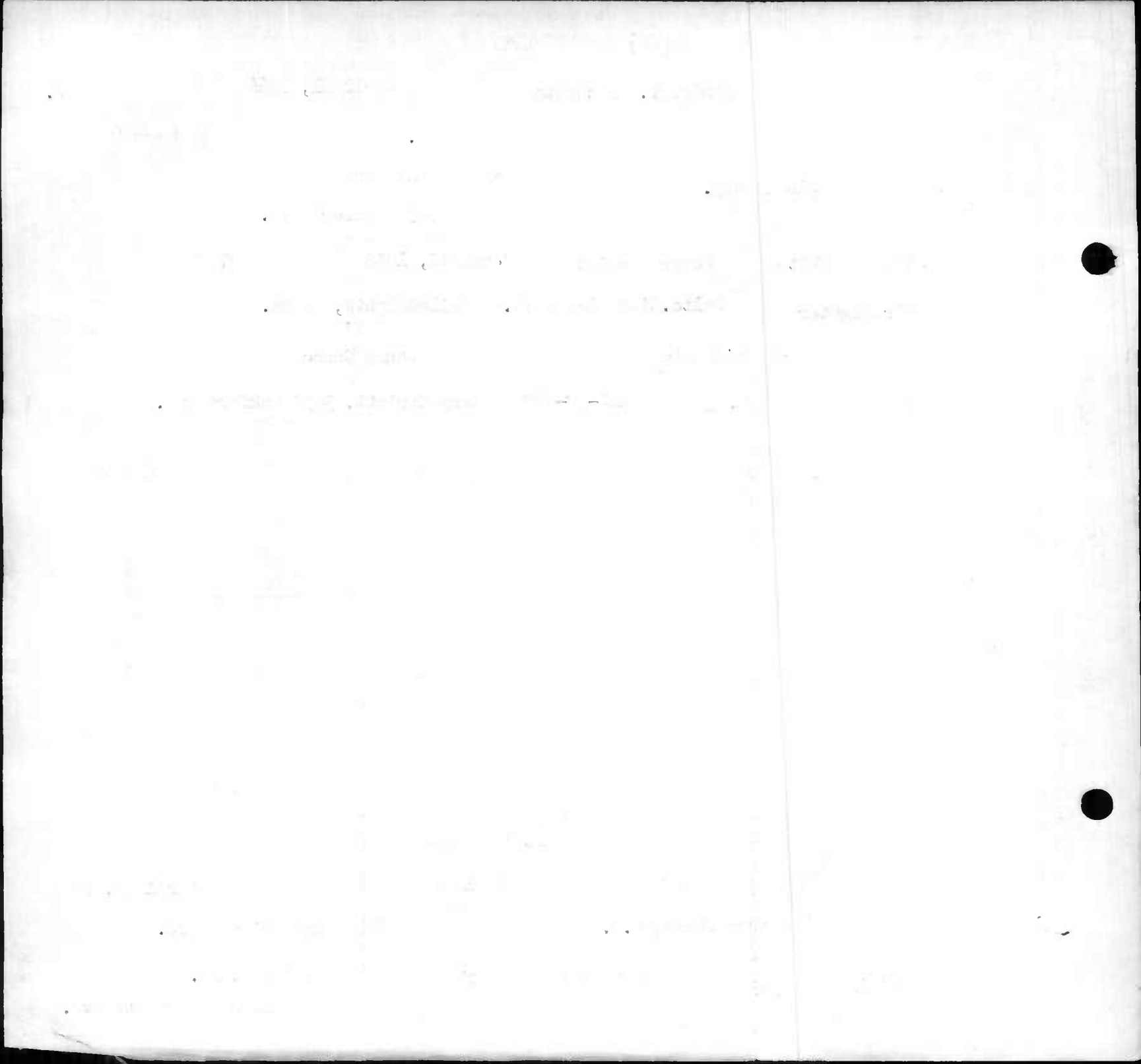
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|---------|--|--|---|--|----------------------------|--|----------------------------------|---------------------------------|--|
| 66 04165 CERTIFICATE OF DEATH | | | | | Registered No. 66 04165 | | | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| Daniel T. Brichetto | | | | | April 21, 1966 P. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)

Sinai Hosp. | | | | | A. STATE
Md. | | | | | |
| | | | | | B. COUNTY | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
3038 Oakford Ave. | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | | 10. Under 1 Yr.
Months Days | | 11. Under 24 Hrs.
Hours Min. | |
| Male | White | Never Married | | June 10, 1888 | 77 | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Firefighter | | | Balto. City Fire Dept. | | Philadelphia, Penna. | | | | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Paul Brichetto | | | | | Laura Cuneo | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | |
| Yes W # 1 | | | 212-30-9480 | | Mary Carioti, 3038 Oakford Ave. | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) DUE TO | | | Canceroma Lung 6 mos? | | |
| | | | | | (B) DUE TO | | | | | |
| | | | | | (C) DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 3/66 | | Biopsy - cervical node. | | | no | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/27/65 to 4/21/66, that (I) (we) last saw the deceased alive on 4/21/66, 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED | | |
| Joseph Shear, M.D. | | | | | 6715 Park Heights Ave. | | | April 23, 1966 | | |
| | | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS | | | | | |
| | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 4/25/66 | | Cathedral Cemetery | | | Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR | | | 25C. FUNERAL DIRECTOR | | | ADDRESS | |
| APR 25 1966 | | | Robert E. Carley | | | Vernon L. Lamm | | | 4611 Park Heights Ave. | |



BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 66 0411 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04166

M.E. CASE NO.

| | | | | | | | |
|---|-------------------------|--|---|--|--|---|---|
| 1. NAME OF DECEASED
(Type or Print) NICHOLAS VOGELSANG JR. | | | | 2. DATE AND HOUR PRONOUNCED DEAD
April 18, 1966 7:45 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

MERCY HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 19-03

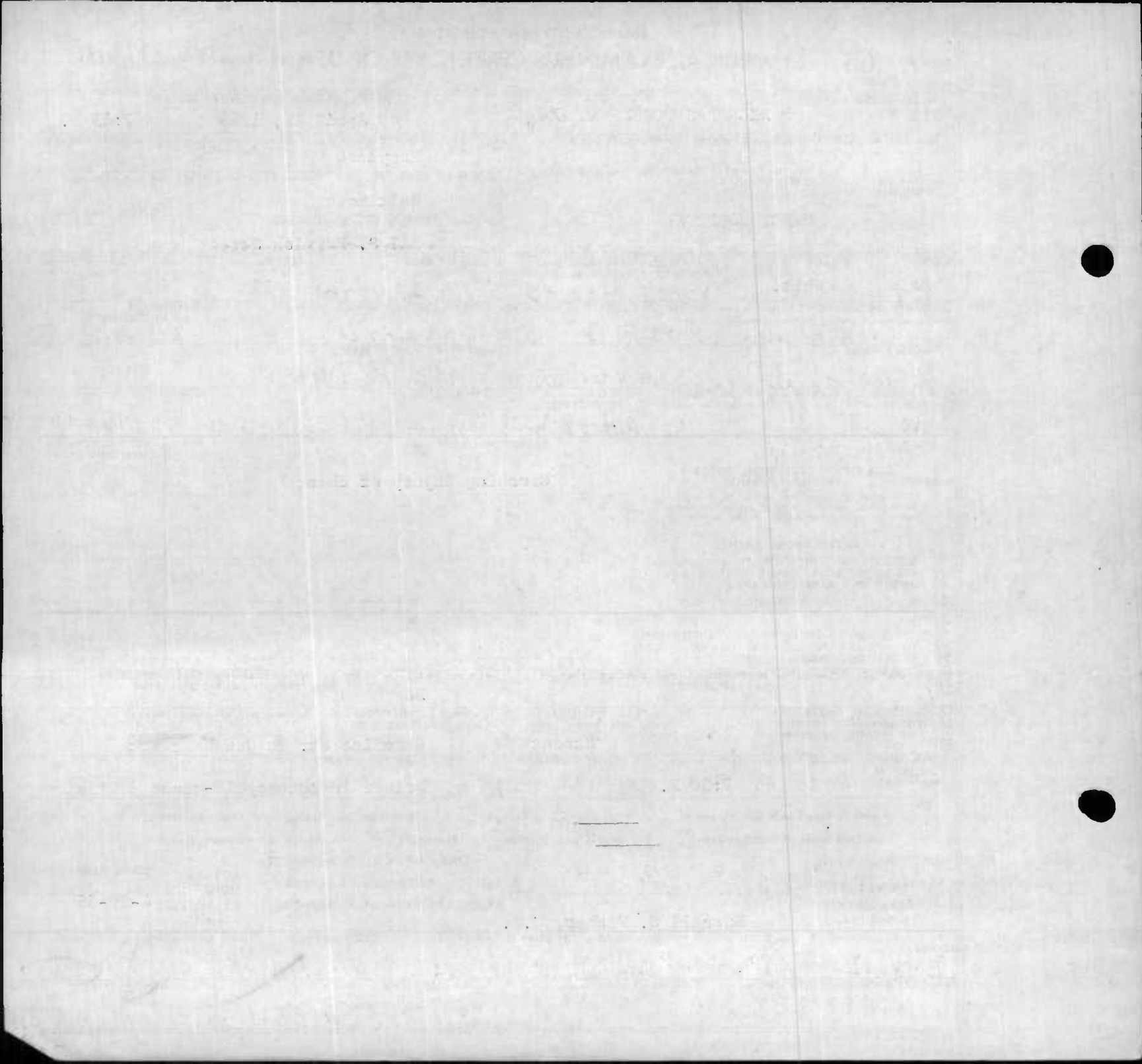
D. STREET ADDRESS (If rural, give location)
317 S. Parrish Street | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
NEVER MARRIED | 8. DATE OF BIRTH
SEPT. 27-1946 | 9. AGE (In years last birthday)
19 | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
WAREHOUSE MAN | | | 10B. KIND OF BUSINESS OR INDUSTRY
PAPER CO. | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
NICHOLAS J. VOGELSANG SR. | | | | 14. MOTHER'S MAIDEN NAME
MAE E. DUNN | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
214-44-3620 | 17. INFORMANT ADDRESS
NICHOLAS VOGELSANG SR 317 S. PARRISH ST. | | | |
| 18. E 8/13. 1/
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Crushing injury of chest
(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Street | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Caroline St. at Gough Street 3-01 | | |
| 21D. TIME OF INJURY (APPROX.)
4 18 66 7:30 P.M. | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Driver in motorcycle-truck collision | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Russell S. Fisher, M.D. | | | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DATE SIGNED
4-19-66 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 23B. DATE
APR. 22-1966 | | 23C. NAME OF CEMETERY or CREMATORY
BALTIMORE NATIONAL | | 23D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 24A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | 24B. NAME OF REGISTRAR
Robert E. Bailey, M.D. | | 24C. FUNERAL DIRECTOR ADDRESS
WALTERS FUNERAL HOME STRICKER ST. PRATT 4 | | | |



BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

BERTHA

COHEN

2. DATE AND HOUR PRONOUNCED DEAD

April 21, 1966

4:10 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2637 Quantico Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

Sept 15, 1905

9. AGE (In years
last birthday)

60

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

OPERATOR

10B. KIND OF BUSINESS OR INDUSTRY

RALEIGH MFG CO

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

HARRY

14. MOTHER'S MAIDEN NAME

BASHEBA

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

215-05-6226

17. INFORMANT

ALBERT COHEN-

ADDRESS

SAME

18. 720.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/22/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

4/22/1966

23C. NAME OF CEMETERY OR CREMATORY

ROSEDALE

23D. LOCATION

BRLTO.

(City, town, or county)

(State)

MD

24A. DATE REC'D BY HEALTH DEPT.

APR 25 1966

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

SYLVAN S. LEWIS & Son, Inc. 3319 OLYMPIA AVE

ADDRESS

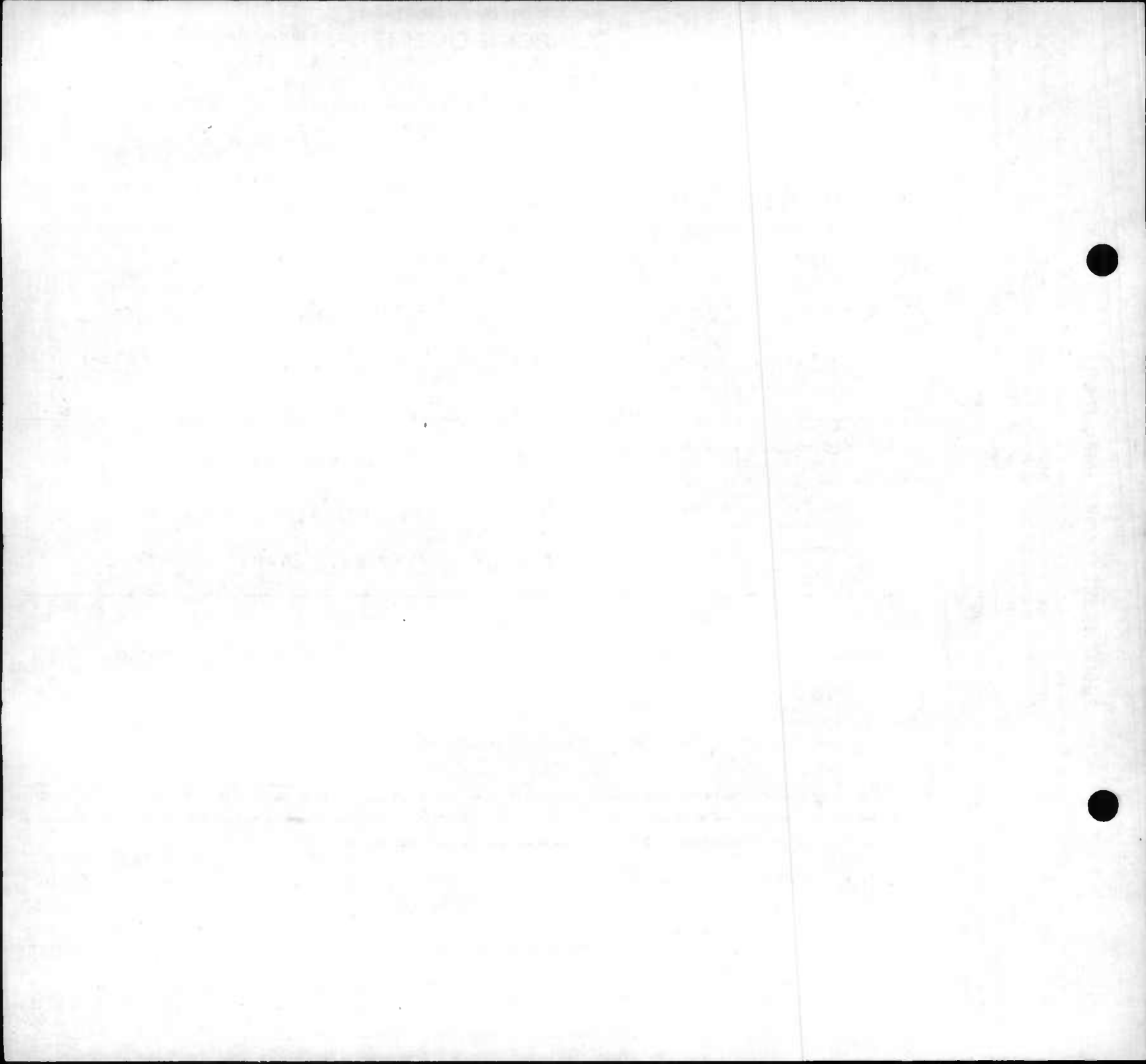
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Handwritten text, possibly a signature or name, appearing in the lower right quadrant of the page.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed.

| | | | | | |
|--|---------------------|--|---------------------------------------|--|---|
| BIRTH NO.
66 04168 | | CITY HEALTH DEPARTMENT
BALTIMORE CITY | | Registered No.
66 04168 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print)
COMBS - J. FRANK | | 2. DATE AND HOUR OF DEATH
4-21-1966 1:30 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION
MERCY HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MD. B. COUNTY ST. MARYS
C. CITY OR TOWN (If outside city limits, write RURAL and give township) COLITORNIA 68-00
D. STREET ADDRESS (If rural, give location) RURAL | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
11-23-1875 | 9. AGE (In years last birthday)
90 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FARMER | | 10B. KIND OF BUSINESS OR INDUSTRY
FARM OWNER | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 13. FATHER'S NAME
Joseph Combs - (dec) | | 14. MOTHER'S MAIDEN NAME
ALICE Wheeler (dec) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
— | | 16. SOCIAL SECURITY NO.
220 22 1580 | | 17. INFORMANT
MRS. IRVING HEWITT - Callaway, Md. | |
| 18. 466X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
MASSIVE PULMONARY INFARCTION | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
RIGHT PULMONARY ARTERY EMBOLISM
LOWER EXTREMITIES VENOUS THROMBOSIS | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (s) (this hospital) attended the deceased from 4-8-1966 to 4-21-1966 , that (s) (we) lost saw the deceased alive on 4-21-1966 and that in (s) (our) opinion death occurred on the date and hour and from the causes stated above. (s) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Joseph Notarangelo M.D. | | | | 23B. DATE SIGNED
4-21-1966 | |
| 23C. PHYSICIAN'S NAME (Type)
JOSEPH NOTARANGELO M.D. | | | | 23D. ADDRESS
MERCY HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4-25-66 | | 24C. NAME OF CEMETERY or CREMATORY
HOLY FACE CEMETERY | |
| 24D. LOCATION (City, town, or county) (State)
GREAT MILLS MD. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR
P. B. Robinson - Leonardtown, Md. | |

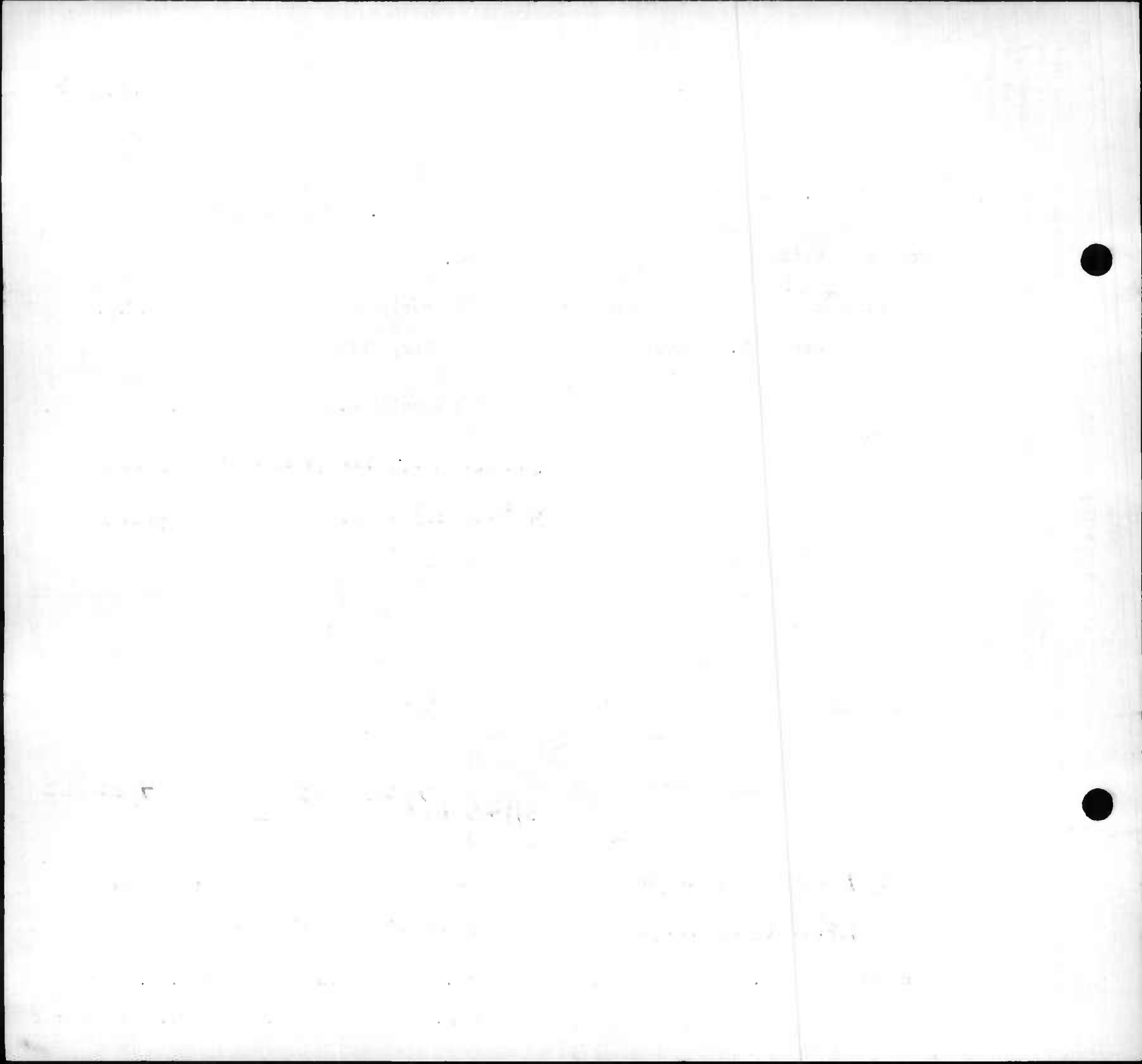


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|--|---|---|--|--|------------------------------------|--|--|
| 66 04169 CERTIFICATE OF DEATH | | | | | Registered No. 66 04169 | | | | |
| BIRTH NO.
M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) ROSALIA M. SHRIVER | | | | | 2. DATE AND HOUR OF DEATH
April 22, 1966 7:15 P M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
141 W. Lanvale Street | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 1102
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
141 W. Lanvale Street | | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
Nov. 8, 1885 | 9. AGE (In years last birthday)
80 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Philadelphia, Penna | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Joseph M. Oliver | | | | | 14. MOTHER'S MAIDEN NAME
Mary Phillips | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Miss Rosalia O. Shriver | | | | |
| | | | | | ADDRESS
141 W. Lanvale St. (17 | | | | |
| 18. 331X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cerebrovascular Accident
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Anteriosclerosis | | | | | CAUSE OF DEATH
(A) Cerebrovascular Accident
DUE TO
(B) Anteriosclerosis
DUE TO
(C) years. | | | | |
| INTERVAL BETWEEN ONSET AND DEATH
Sudden | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/14 1966 to 4/22 1966 that (I) last saw the deceased alive on 3/14 1966 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) we (did) did not view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
J. Frank Supplee, III | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/23/66 | | |
| 23C. PHYSICIAN'S NAME (Type)
J. Frank Supplee, III | | | | | 23D. ADDRESS
M.D. 1010 St Paul St., Balt 2. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Apr. 25, 66 | | 24C. NAME OF CEMETERY or CREMATORY
Lorraine Park Cem. | | 24D. LOCATION (City, town, or county) (State)
Woodlawn Balto. Co. Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
ADDRESS
Wm. Cook-Brooks, Inc. 1217 St. Paul Street | | | | | |



1
6-640

66 04170

BALTIMORE CITY HEALTH DEPARTMENT

66 04170

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

WILLIAM LEE GOURLEY

2. DATE AND HOUR PRONOUNCED DEAD

April 21, 1966 6:55 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

405 N. Paca Street

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

405 N. Paca Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

12/24/95

9. AGE (In years
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Jockey Valet

10B. KIND OF BUSINESS OR INDUSTRY

Md. Jockey Club

11. BIRTHPLACE (State or foreign country)

New York State

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-07-0025

17. INFORMANT

ADDRESS

Mrs. Mary Gourley 405 N. Paca St. Balt. Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/21/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/25/66

23C. NAME of CEMETERY or CREMATORY

Gardens of Faith

23D. LOCATION (City, town, or county) (State)

Baltimore County, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 25 1966

Wm. Cook-Brooks Inc. 1217 St. Paul St
Baltimore, Md.

VALLEY FORGE

PAGE 10

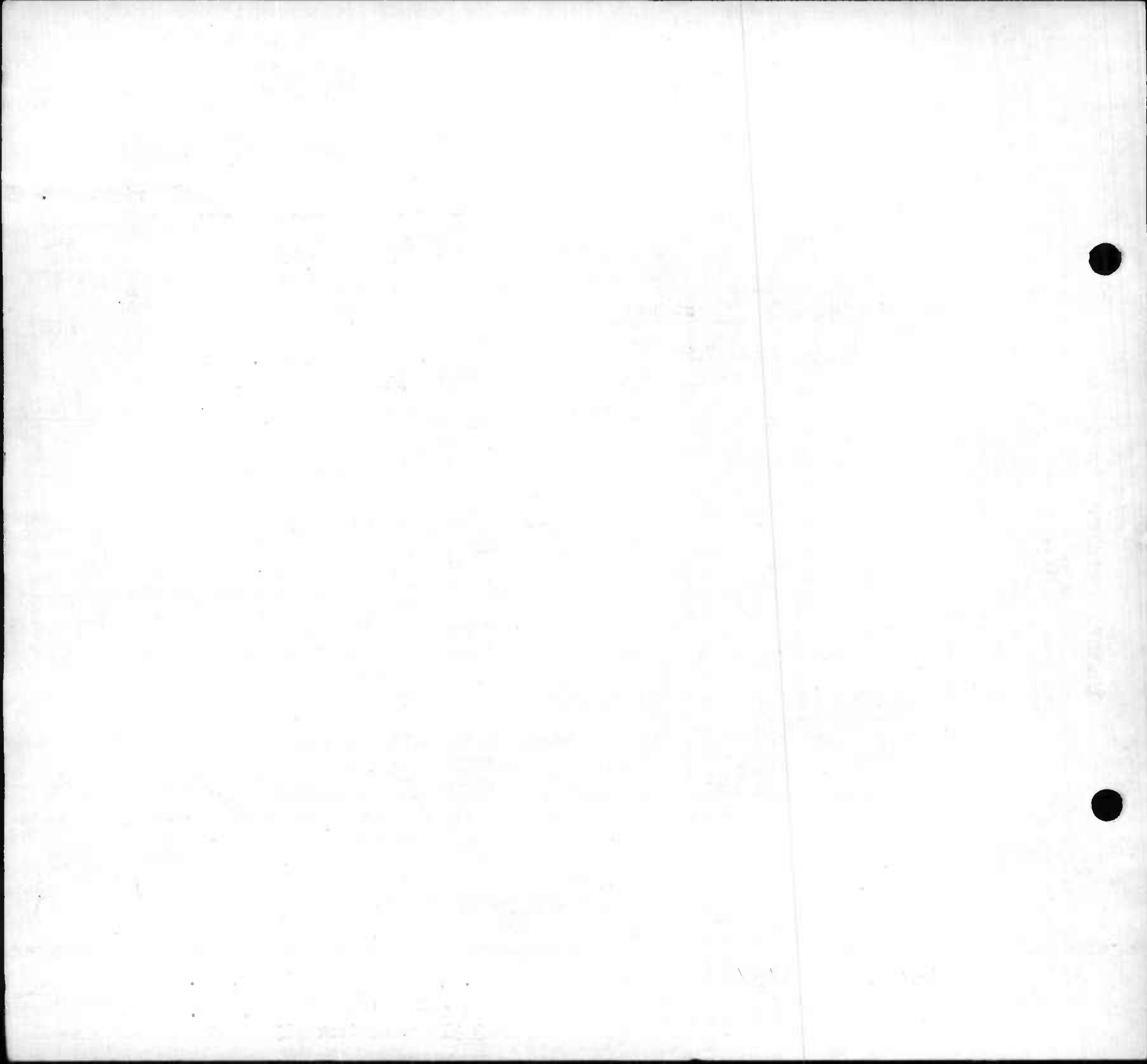
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|---|--|---|--|--------------------------------|---|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>66 04171</u> | | | | |
| BIRTH NO. <u>66 04171</u> | | M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH <u>April 21, 1966 1 3¹⁵ A.M.</u> | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Elizabeth E/1/A De Angelo</u> | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Maryland General Hosp Baltimore Md.</u> | | | | | A. STATE <u>MD</u> | | | | |
| | | | | | B. COUNTY <u>26-34</u> | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Balto</u> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <u>5061 Wright Ave. #5</u> | | | | |
| 5. SEX <u>F</u> | | 6. RACE <u>Cau</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | | 8. DATE OF BIRTH <u>9/1/06</u> | | 9. AGE (In years last birthday) <u>79</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>Unc James Vain</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Unc Ella E. Tarr</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>Daughter, Deborah Wagner</u> | | | ADDRESS <u>1417 3rd St.</u> | | |
| 18. <u>4-22-1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | CAUSE OF DEATH | | | | |
| | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> | | | | |
| MEDICAL CERTIFICATION | | | | | 19A. DATE OF OPERATION <u>0</u> | | | | |
| | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| 20A. AUTOPSY? (Yes or No) <u>No</u> | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | | 21E. INJURY OCCURRED | | | | |
| | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/17</u> 19 <u>66</u> to <u>4/21</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/21</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | | | | 23B. DATE SIGNED <u>4-21-66</u> | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS | | | | |
| | | | | | M.D. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>4/25/66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Dulaney Valley Mem. Gardens</u> | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>APR 25 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u> | | | 25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> | | | ADDRESS <u>3331 Brohms Lane #13</u> | |

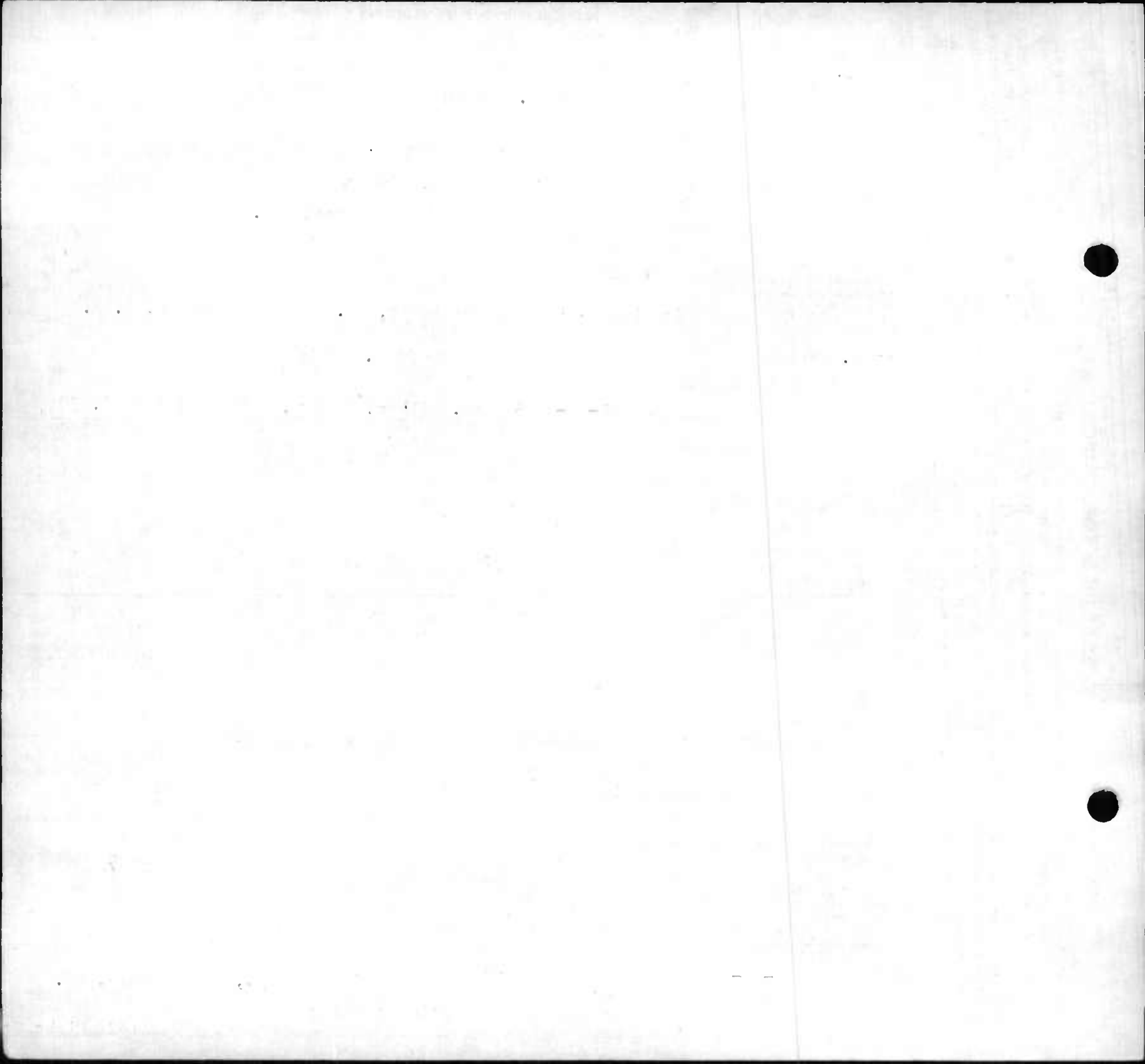


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

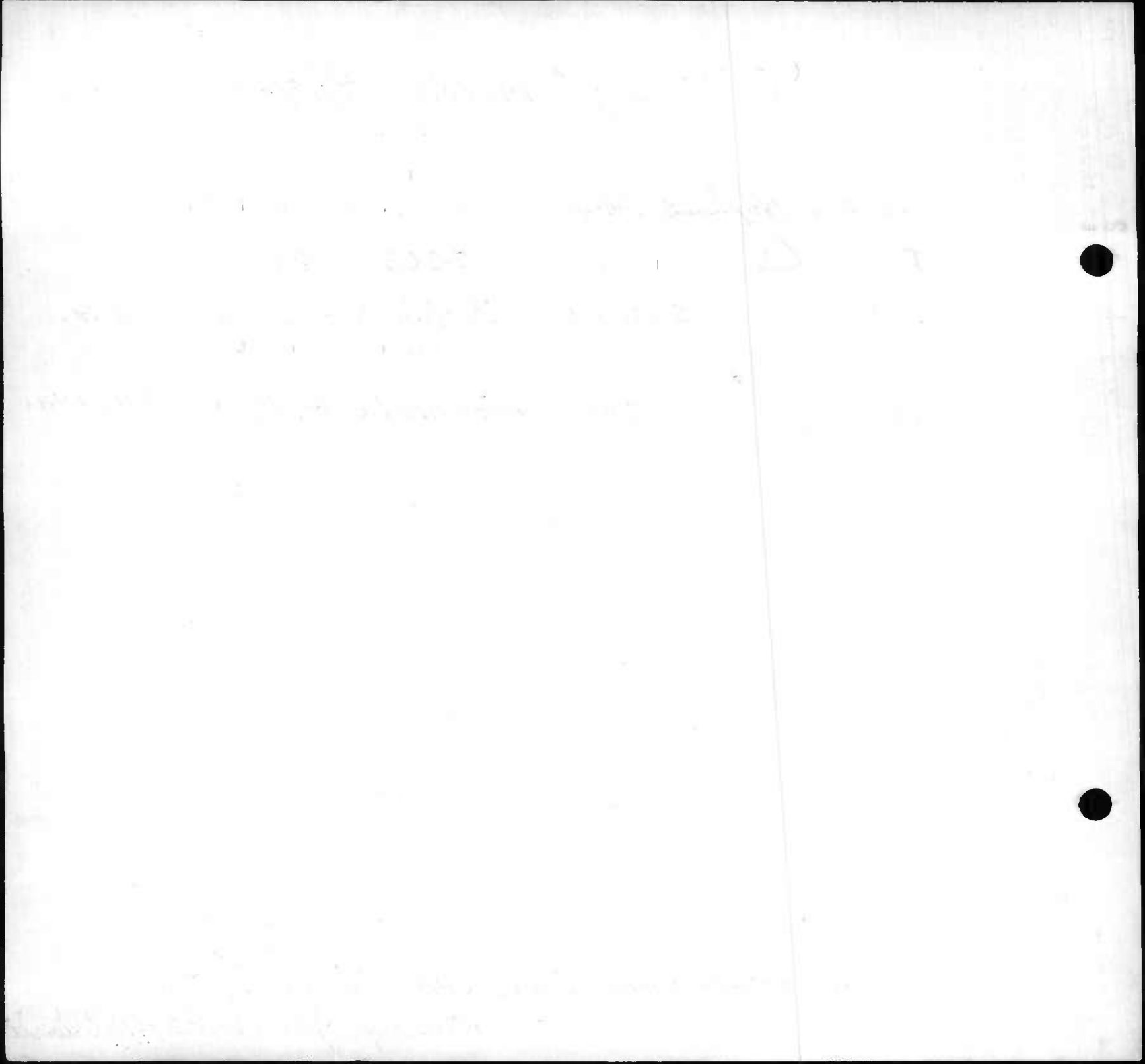
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. | |
|---|---------------------|--|--|--|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | 66 04172 | |
| BIRTH NO.
66 04172 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print)
<i>Barton Henry</i> | | | | 2. DATE AND HOUR OF DEATH
<i>4-22-66</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
<i>37 Mercy Hospital</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
<i>Maryland</i>
B. COUNTY
<i>10-01</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i>
D. STREET ADDRESS (If rural, give location)
<i>1208 Homewood Ave.</i> | | | | | | | |
| 5. SEX
<i>M</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Never married</i> | | 8. DATE OF BIRTH
<i>9-9-1900</i> | | 9. AGE (In years last birthday)
<i>65</i> | | 10. Under 1 Yr.
Months Days | | 11. Under 24 Hrs.
Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Bendix, Retired</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore, Md.</i> | | | 12. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> | | |
| 13. FATHER'S NAME
<i>Harry J. Barton</i> | | | | | | 14. MOTHER'S MAIDEN NAME
<i>Amelia C. Kendell</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | | 16. SOCIAL SECURITY NO.
<i>217-14-3848</i> | | 17. INFORMANT ADDRESS
<i>Mrs. Wilbert Cooley, 2951 Mallview Rd. 30</i> | | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>CVA. poss. cerebral hemorrhage</i>
INTERVAL BETWEEN ONSET AND DEATH
<i>2 days</i> | | | | | | | | | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>Arteriosclerosis</i> | | | | | | | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<i>ASCVD, CHF</i> | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <i>(H)</i> (this hospital) attended the deceased from <i>4-19</i> 19 <i>66</i> to <i>4-22</i> 19 <i>66</i> , that <i>(H)</i> (we) last saw the deceased alive on <i>4-22</i> 19 <i>66</i> and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>(H)</i> (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
<i>John R. Ruyko</i> | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>4-22-66</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>WBN-RUYKO</i> | | | | | | | | 23D. ADDRESS
<i>Mercy Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | | 24B. DATE
<i>4-25-66</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Glen Haven Cemetery</i> | | | 24D. LOCATION (City, town, or county) (State)
<i>Ritchie Hwy., Glen Burnie, Md.</i> | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>APR 25 1966</i> | | | | 25B. NAME OF REGISTRAR
<i>Robert E. Jackson</i> | | | | 25C. FUNERAL DIRECTOR
<i>Fleming</i>
ADDRESS
<i>1422 Light St</i> | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>66 04173</u> | |
|---|---------------------------|---|-----------------------------------|---|----------------------------|--|-----------------------------|
| BIRTH NO. <u>66 04173</u> | | M.E. CASE NO. <u>2-516</u> | | 1. NAME OF DECEASED (Chambers)
<u>Edwarda Mary or Maccie</u> | | 2. DATE AND HOUR OF DEATH
<u>4/18/66</u> <u>1</u> <u>P</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
<u>Johns Hopkins Hosp</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MARYLAND</u> B. COUNTY <u>5-07</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Johns Hopkins Hosp</u> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>1742 E. PRESTON STREET</u> | | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>COLORED</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>DIVORCED</u> | 8. DATE OF BIRTH
<u>5-9-03</u> | 9. AGE (In years
last birthday)
<u>62</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Cook</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>School</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Buckingham Co. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>GEORGE CHAMBERS</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>CATHERINE HARTWELL</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>219-22-3187</u> | | 17. INFORMANT ADDRESS
<u>Dillwyn, Va.</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
<u>MASSIVE ANASARCA WITH PLEURAL EFFUSIONS AND PULMONARY EDEMA</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>DAYS</u> | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>DIABETES MELLITUS AND HASCVD WITH CONGESTIVE FAILURE</u> | | | | <u>YEARS</u> | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>April 18 1966</u> to <u>18 April 1966</u> , that (I) (we) last saw the deceased alive on <u>April 18 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>W. Leigh Thompson</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>Interne 18 April 66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>W. Leigh Thompson</u> | | | | 23D. ADDRESS
<u>Osler; Johns Hopkins Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Removal</u> | | 24B. DATE
<u>4-22-66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Moners Valley Ctry. Dillwyn, Va.</u> | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 25 1966</u> | | 25B. NAME OF REGISTRAR
<u>R. E. E. E.</u> | | 25C. FUNERAL DIRECTOR
<u>Randolph J. Collick</u> | | ADDRESS
<u>3431 E. Oliver</u> | |



B. 260

66 04174

BALTIMORE CITY HEALTH DEPARTMENT

66 04174

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) CLARENCE E. BOOKER 2. DATE AND HOUR PRONOUNCED DEAD April 19, 1966 8:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2723 Beryl Ave. 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2723 Beryl Ave.

5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married 8. DATE OF BIRTH 1-11-1922 9. AGE (In years last birthday) 44 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman Steamship Co. 11. BIRTHPLACE (State or foreign country) Maherrin, Va. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edward Booker 14. MOTHER'S MAIDEN NAME Lelia Doswell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 230-03-2151 17. INFORMANT Mrs. Rosetta Booker 2723 Beryl Ave.

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) Hypertensive cardiovascular disease DUE TO (B) DUE TO (C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fatty metamorphosis of the liver

19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

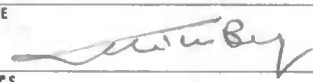
22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D. DATE SIGNED 4-20-66

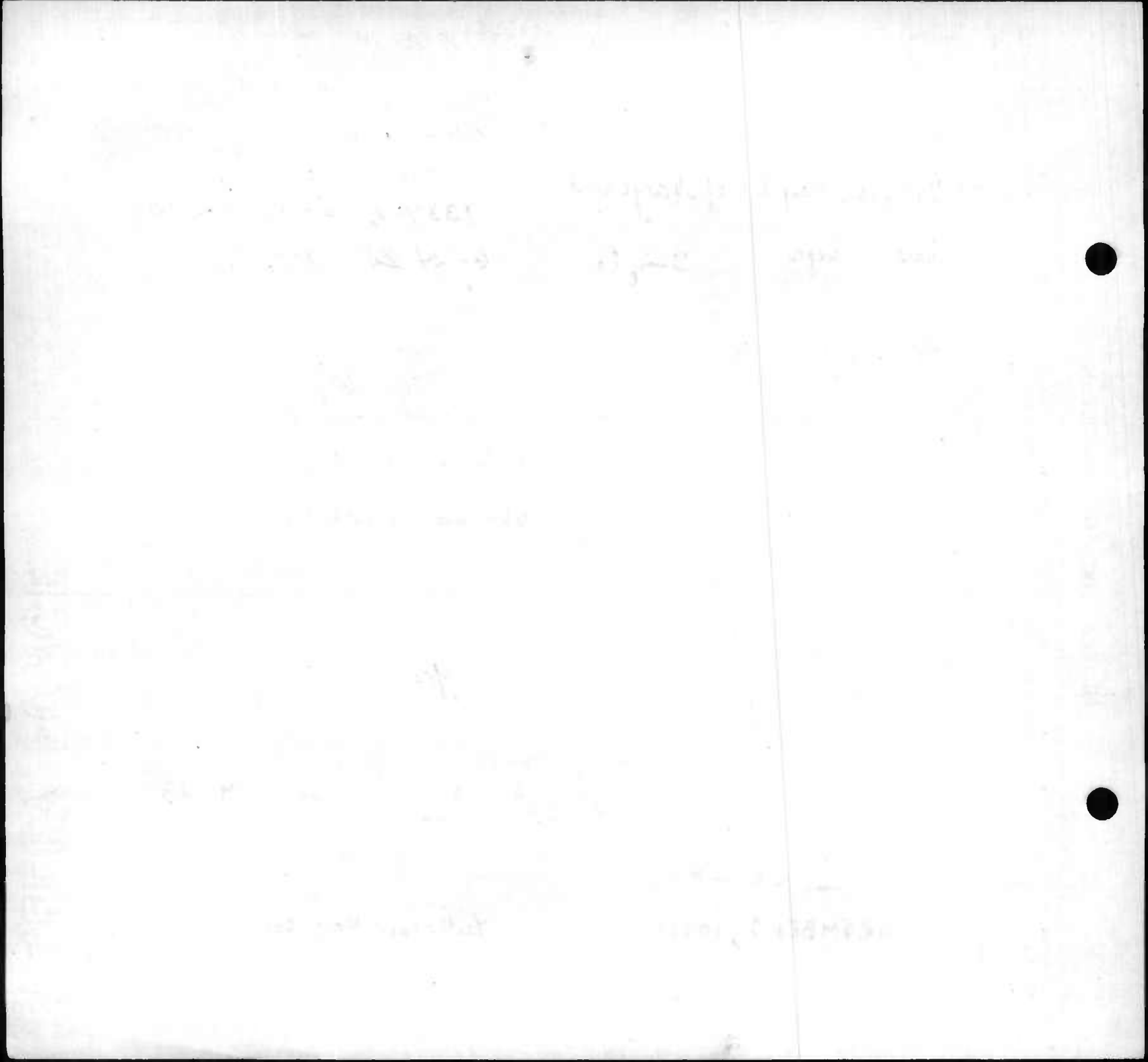
23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 4-23-66 23C. NAME OF CEMETERY or CREMATORY Ambatus Mem. PK. Ambatus, Maryland 23D. LOCATION (City, town, or county) (State) 24A. DATE REC'D BY HEALTH DEPT. APR 25 1966 24B. NAME OF REGISTRAR Robert E. ... 24C. FUNERAL DIRECTOR ADDRESS Randolph J. Collick 2431 E. Oliver St.

WILEY-INTERSCIENCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04175 | |
|--|-------------------------|--|------------------------------------|--|--|
| BIRTH NO. 66 04175 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) DWENS, ROBERT | | 2. DATE AND HOUR OF DEATH
4. 23 1966 5¹⁵ P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 16-01 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Lutheran Hospital of Maryland | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location)
1337 N. Starkey St. | | | |
| 5. SEX
Male | 6. RACE
negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
6-24-23 | 9. AGE (In years lost by)
42 | If Under 1 Yr. Months: Days: Hours: Min.
If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Clemson SC | |
| 13. FATHER'S NAME
Henry Owens | | 14. MOTHER'S MAIDEN NAME
Mary Lou Green | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
249-32-643 | | 17. INFORMANT
Martha Payton
2136 Walbrook Ave Baltimore | |
| 18. 322.1 I | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | (A) Acute pancreatitis
DUE TO | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Chronic alcoholism
DUE TO | | | |
| | | (C) | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22. I certify that (I) (this hospital) attended the deceased from 4. 18 1966 to 4. 23 1966 , that (I) (we) last saw the deceased alive on 4. 23 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
 | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
GRUMBERG, JOSEF | | 23D. ADDRESS
M.D. Lutheran Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4. 28 66 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Martha E. McCune
2302 W North Ave | |

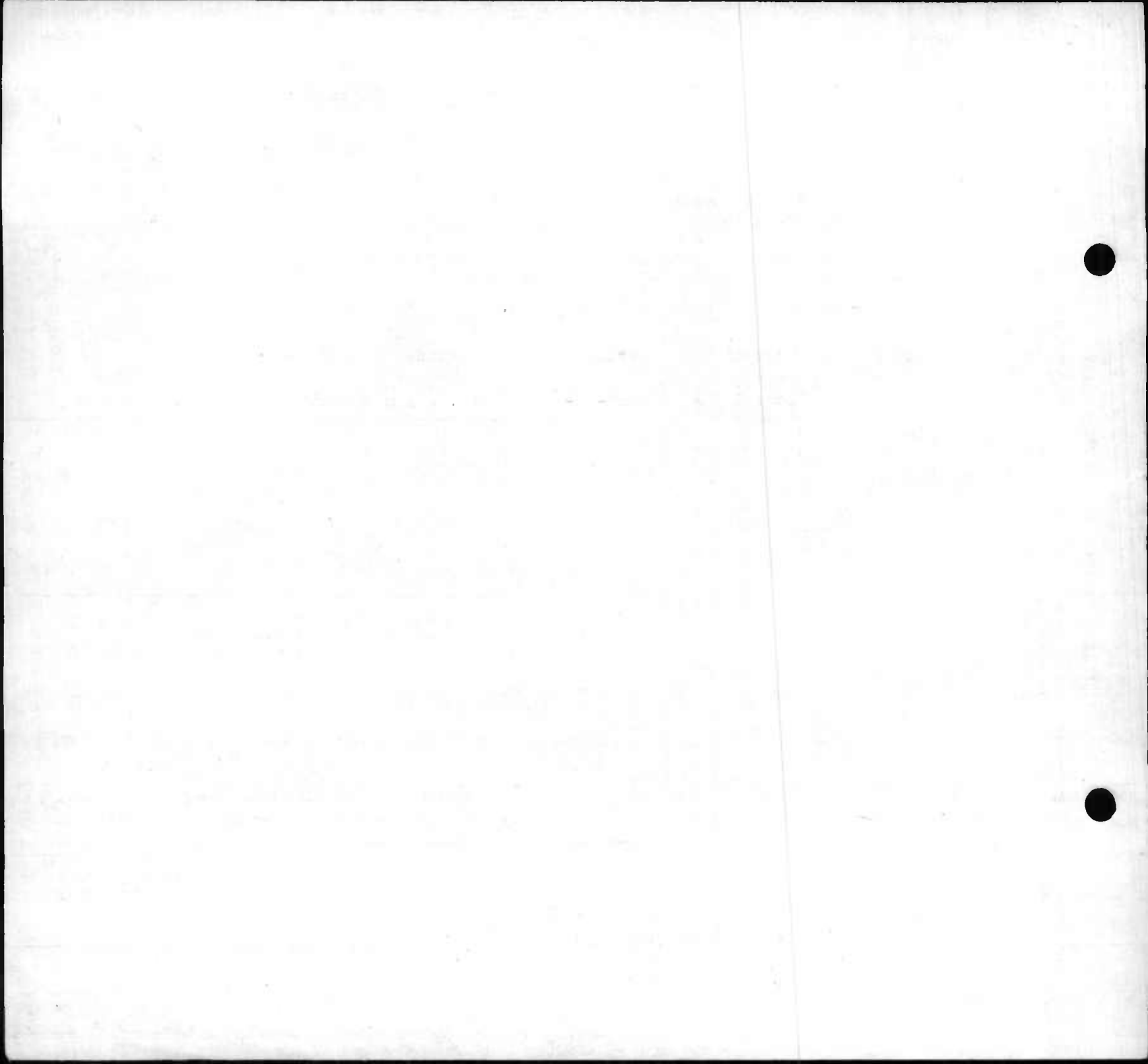


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---|---|--|---|--|
| BIRTH NO. 66 04176 | | BALTIMORE CITY HEALTH DEPARTMENT | | REGISTERED NO. 66 04176 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) James Frederick Magill | | | 2. DATE AND HOUR OF DEATH
April 24, 1966 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland B. COUNTY 15-48 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
90 Anderson Nursing Home
3604 Mohawk Avenue
Baltimore, Maryland 21207 | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location)
3501 Gwynns Falls Parkway 16 | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
March 5, 1881 | 9. AGE (In years last birthday)
85 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired - Owner | | | 10B. KIND OF BUSINESS OR INDUSTRY
Weatherstripping Co. | | 11. BIRTHPLACE (State or foreign country)
Maryland |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | |
| 13. FATHER'S NAME
James Frederick Magill | | | 14. MOTHER'S MAIDEN NAME
Amanda Goldsborough | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No None | | | SOCIAL SECURITY NO.
218-32-2499 | | 17. INFORMANT
4101 Bel Pre Road
Mrs. Helen Shaudis Rockville, Maryland |
| 18. 420.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) Arterio-sclerotic Heart Disease
DUE TO
(B) Broncho-pneumonia
DUE TO
(C) Chronic Prostatitis | | INTERVAL BETWEEN ONSET AND DEATH
3 yrs.
2 days
- 6 months |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Generalized Arterio Sclerosis | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 21, 1966 to April 24, 1966 , that (I) (we) last saw the deceased alive on April 23, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Earl L. Chambers | | | | 23B. DATE SIGNED
4/25/66 | |
| 23C. PHYSICIAN'S NAME (Type)
Earl L. Chambers | | | | 23D. ADDRESS
M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/27/1966 | | 24C. NAME of CEMETERY or CREMATORY
New Cathedral Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | 25B. NAME OF REGISTRAR
Wm. J. Tichner | | 25C. FUNERAL DIRECTOR
Wm. J. Tichner & Sons | |
| ADDRESS
Baltimore, Md. 17 North 2nd Ave. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>86 04177</u> | |
|--|------------------|---|-------------------------------------|---|---|--|---|
| BIRTH NO. <u>66 04177</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>IDA V. Kirwan</u> | | 2. DATE AND HOUR OF DEATH
<u>4-21-66</u> <u>11:20 A.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Church Home & Hosp.</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>6-05</u> | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | D. STREET ADDRESS (If rural, give location) <u>100 N Broadway St</u> | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>WIDOWED</u> | 8. DATE OF BIRTH <u>1-30-88</u> | 9. AGE (In years last birthday) <u>88</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>MARTIN WHEMEYER</u> | | | | 14. MOTHER'S MAIDEN NAME <u>HANNAH Whameyer</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT ADDRESS
<u>Mrs. Walter C. Kirwan 1530 Stonewood Rd</u> | | |
| 18. <u>4-20-0 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>ARTERIOSCLEROTIC HEART DISEASE</u> | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | (B) DUE TO | |
| | | | | (C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | <u>RENAL SHUT DOWN; EMBOLUS (2) FEMORAL</u> | | | |
| 19A. DATE OF OPERATION <u>4-19-66</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>corbectomy, left femoral</u> | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (netly medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4-11-66</u> 19 <u>66</u> to <u>4-21</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4-21</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Dr. A. Waisog</u> M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>4-21-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. S. Waisog M.D.</u> | | | | 23D. ADDRESS <u>Church Home & Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 24B. DATE <u>4.23/1966</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Greenmount Crematory</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>APR 25 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Galt</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>Wm. J. Fickner & Sons Baltimore, Md.</u> | | | |

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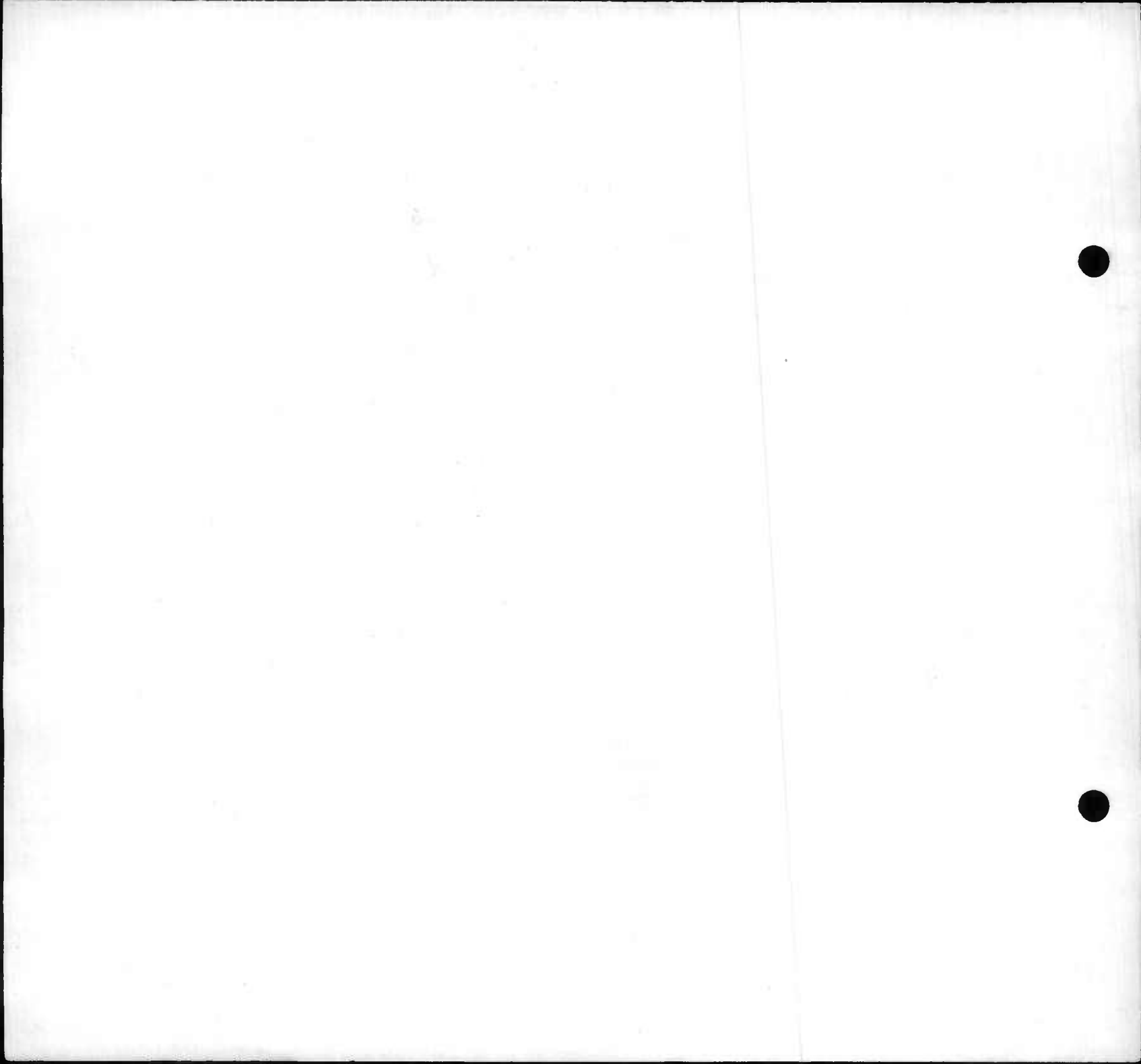
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04178 | |
|--|-----------|---|--------------------------|--|----------------------------------|
| BIRTH NO. 66 04178 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MR. EDWARD PARRISH | |
| 2. DATE AND HOUR OF DEATH 4-20-66 3:45 P.M. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 9-06 | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21218 | | D. STREET ADDRESS (If rural, give location) 2928 HARFORD ROAD | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH 6-21-01 | 9. AGE (In years last birthday) 64 YRS. | 10. CITIZEN OF WHAT COUNTRY? USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior Decorator | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) GEORGIA | |
| 13. FATHER'S NAME Oscar M. Parrish | | 14. MOTHER'S MAIDEN NAME Troupie Crenshaw | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS The Union Memorial Hospital Records | |
| 18. 370.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) PERITONITIS SECONDARY TO MESENTERIC THROMBOSIS (B) CIRRHOSIS OF LIVER (C) CIRRHOSIS OF LIVER | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cirrhosis of liver | | 19A. DATE OF OPERATION 4/18/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute Abdomen | |
| 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (this hospital) attended the deceased from 4/18/1966 to 4/20/1966 that (I) (we) last saw the deceased alive on 4/20/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE Godfrey Cieh | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 4/20/66 | |
| 23C. PHYSICIAN'S NAME (Type) GODFREY CIEH | | M.D. 23D. ADDRESS Union Memorial Hospital, Md. | | 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | |
| 24B. DATE 4/21/1966 | | 24C. NAME OF CEMETERY or CREMATORY Hillview Annex | | 24D. LOCATION (City, town, or county) La Grange, Georgia (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 25 1966 | | 25B. NAME OF REGISTRAR R. E. Taylor, MA | | 25C. FUNERAL DIRECTOR Wm. J. Tickner & Sons Baltimore, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>86 04179</u> | |
|---|---------------------|---|------------------------------------|--|--|--|--|
| BIRTH NO. <u>66 04179</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>CHARLOTTE MORISON</u> | | 2. DATE AND HOUR OF DEATH
<u>4-20-66</u> <u>7:40 P.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <u>MARYLAND</u> B. COUNTY <u>27-14</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>UNION MEMORIAL HOSPITAL</u> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE 21210</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>103 BEECHDALE ROAD</u> | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>W</u> | 7. MARRIED NEVER MARRIED
WIDOWED, Divorced (Specify) | 8. DATE OF BIRTH
<u>11-2-90</u> | 9. AGE (In years last birthday) <u>25</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>Henry M. Denison</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Laura Augusta Pearce</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> <u>None</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT <u>DAUGHTER</u>
<u>HELEN HEATON</u> | | ADDRESS
<u>1319 PARK AVE. 21217</u> | |
| 18. <u>331X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>Cerebral hemorrhage</u>
DUE TO
(B) DUE TO
(C) <u>Ant.</u> | | | | CAUSE OF DEATH
INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<u>4/20</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/20</u> 19 <u>66</u> to <u>4/20</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/20</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>PAUL HUDSON FESCHE</u>
<u>Paul Hudson Fesche</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Hudson Fesche</u> | | | | 23D. ADDRESS
M.D. <u>UNION MEMORIAL HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/23/1966</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Green Mount Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 25 1966</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Jackson</u> | | 25C. FUNERAL DIRECTOR
<u>Wm. J. Jackson & Sons</u> ADDRESS <u>Balto. and 17 North L. Pa. Ave.</u> | | | |

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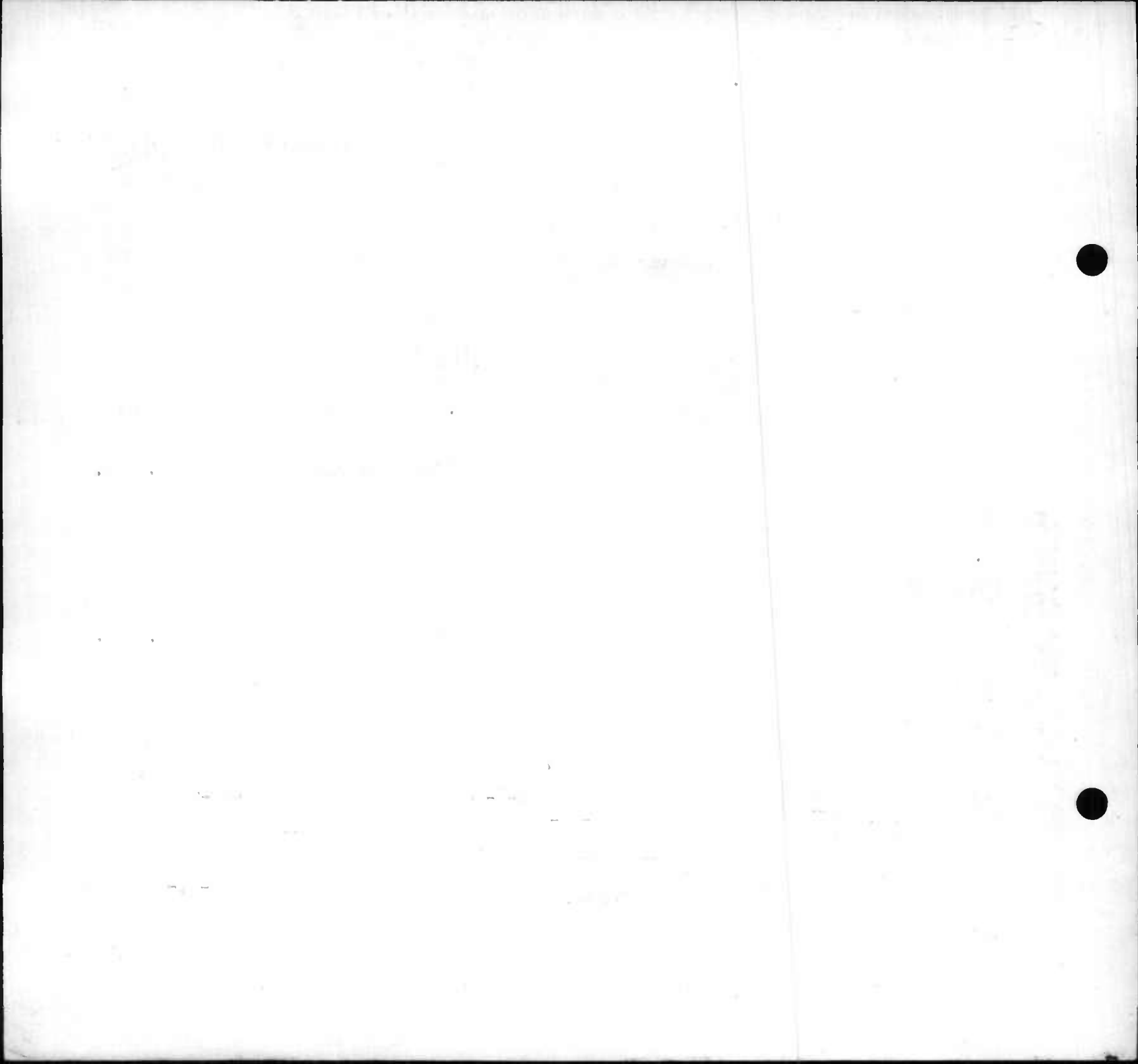
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1000 2000 3000 4000 5000 6000 7000 8000 9000 10000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

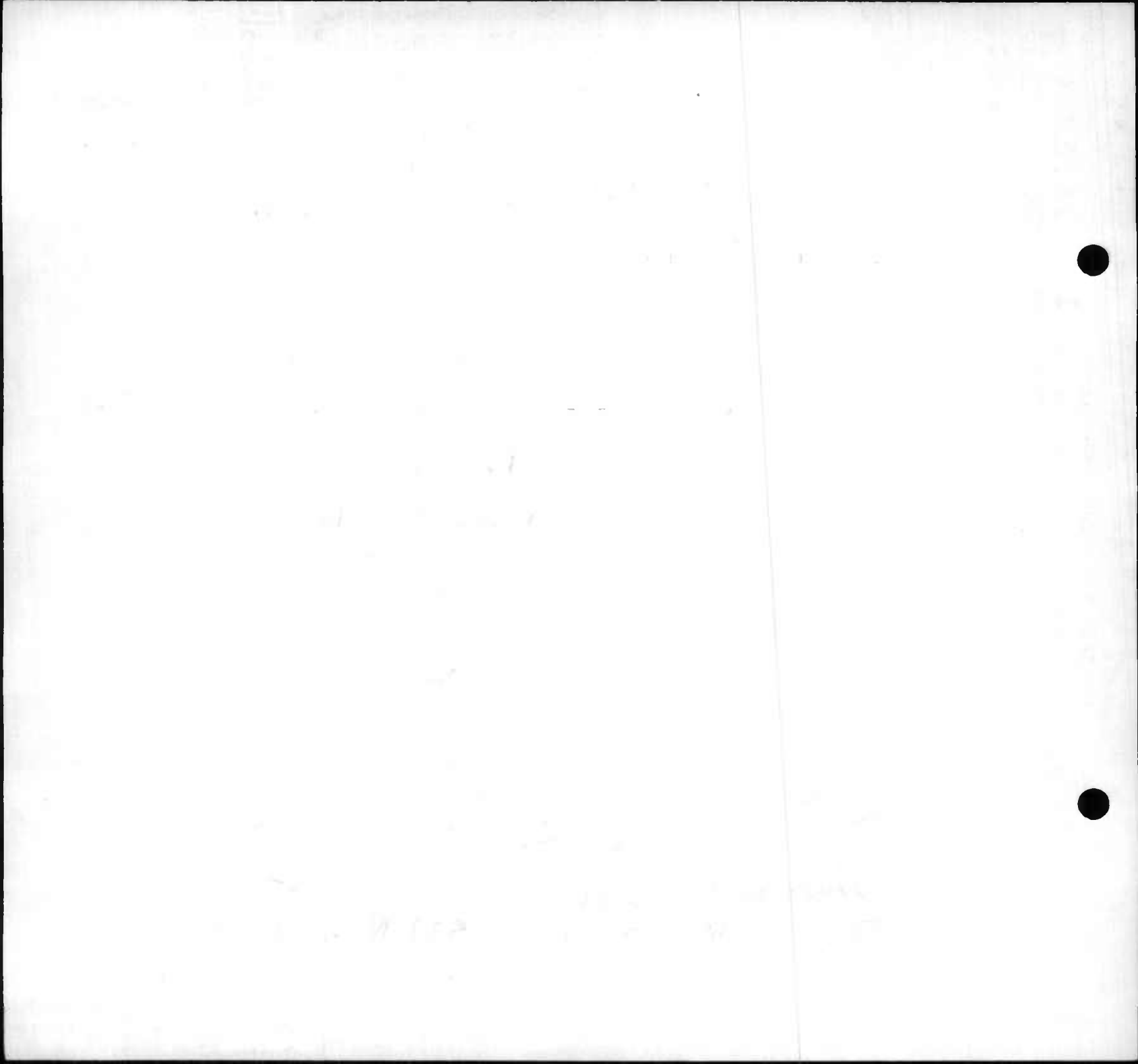
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|--|-------------------------|--|-------------------------------------|--|---|
| BIRTH NO. <u>65-04180</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>86-04180</u> | |
| M.E. CASE NO. <u>July 2 1888</u> | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Killie B. Rawlings</u> | | 2. DATE AND HOUR OF DEATH
<u>Apr 12, 1966</u> <u>9:20 A</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Balton Hill Nursing Center</u> | | A. STATE <u>Maryland</u>
B. COUNTY <u>Baltimore</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore, Maryland</u>
D. STREET ADDRESS (If rural, give location)
<u>12-06</u> | | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>Never Married</u> | 8. DATE OF BIRTH
<u>7/2/1888</u> | 9. AGE (In years last birthday)
<u>77</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired - Clerk</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Post Office</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | 13. FATHER'S NAME
<u>William F. Rawlings</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Mary Sue Garland</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<u>Mrs. Bowersox same address as above</u> | | | |
| 18. <u>450.01</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) <u>generalized arteriosclerosis</u> | | <u>sev. yrs.</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>deafness</u> | | <u>sev. yrs.</u> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>no</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-1-66</u> 19 to <u>4-21-66</u> 19, that (I) (we) last saw the deceased alive on <u>4-20-66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>E. Ellsworth Cook</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>4-21-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/23/1966</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Lorraine Park Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Woodlawn, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 25 1966</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR
<u>Wm. F. Tichenor & Sons</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

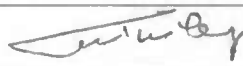
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 66 04181 | |
|--|--|---------------|--|--|--|---|--|--|--|---|--|
| BIRTH NO. 66 04181 | | | | | | | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Mildred M. Sherwood | | | | | | | | | | 2. DATE AND HOUR OF DEATH 4-21-66 5:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | | | | | | | | | A. STATE MARYLAND | |
| | | | | | | | | | | B. COUNTY 11-02 | |
| | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| | | | | | | | | | | D. STREET ADDRESS (If rural, give location) 701 CATHEDRAL ST. 21201 | |
| 5. SEX FEMALE | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE | | 8. DATE OF BIRTH 8-26-98 | | 9. AGE (In years last birthday) 67 | | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME STEPHEN SHERWOOD | | | | | | 14. MOTHER'S MAIDEN NAME BLANCHE WALLACE | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 240-48-2523 | | 17. INFORMANT Miss Elizabeth W. Sherwood same address | | | | | |
| 18. CAUSE OF DEATH | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | (A) Pnuemonia 48 hours | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | (B) Pancreatic Carcinoma 4 years | |
| | | | | | | | | | | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that the (this hospital) attended the deceased from 4-15 1966 to 4-21 1966, that (I) we last saw the deceased alive on 4-21 1966 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) We (did) did not view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Thomas M. Jure M.D. | | | | | | | | | | 23B. DATE SIGNED 4-21-66 | |
| 23C. PHYSICIAN'S NAME (Type) Thomas M. Jure M.D. | | | | | | | | | | 23D. ADDRESS 537 N. Washington St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | | | 24B. DATE 4/23/1966 | | | | 24C. NAME OF CEMETERY OR CREMATORY Greenmount Crematory | | | |
| | | | | | | | | 24D. LOCATION (City, town, or county) Baltimore, Maryland (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 25 1966 | | | | 25B. NAME OF REGISTRAR Robert E. Jure, M.D. | | | | 25C. FUNERAL DIRECTOR Wm. J. Schmitt & Sons Baltimore, Md. | | | |

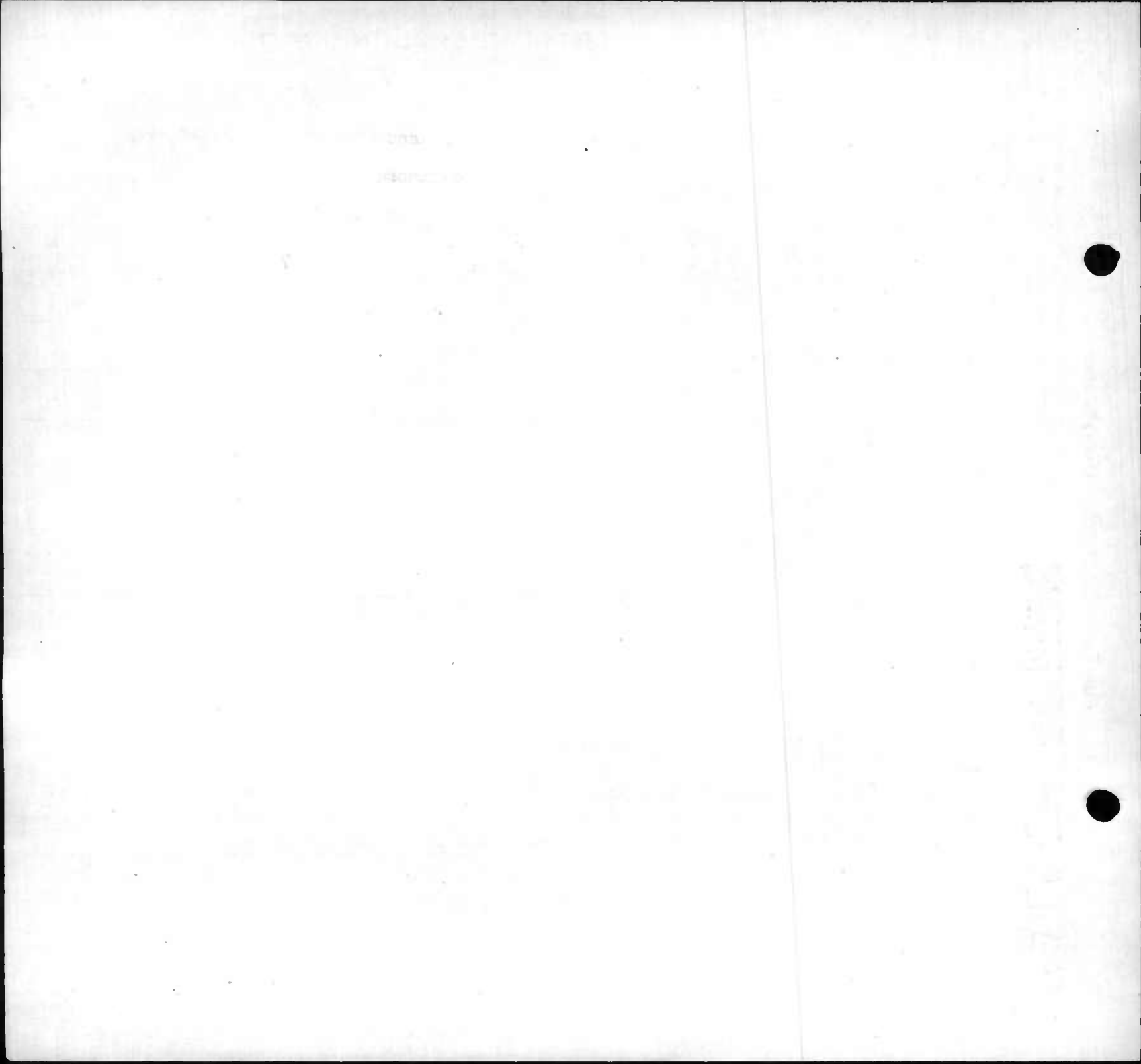


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 04182</u> | |
|--|-------------------------|---|---|--|---|
| BIRTH NO. <u>66 04182</u> | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Baker, Ida May</u> | | 2. DATE AND HOUR OF DEATH
<u>4. 21. 66</u> <u>11 35</u> <u>A</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Lutheran Hospital of Maryland</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY <u>Baltimore</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u>
D. STREET ADDRESS (If rural, give location)
<u>5009 Cordelia Avenue 15</u> | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>widow</u> | 8. DATE OF BIRTH
<u>5/19/08</u> | 9. AGE (In years last birthday)
<u>57</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Homemaker</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Maryland</u> | |
| 13. FATHER'S NAME
<u>Harry E. Shearer</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Emma F. Reeves</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>CHART</u> | |
| 18. <u>434.1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Massive pneumonia - left</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Congestive Heart Failure</u> | | | CAUSE OF DEATH
INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4. 17. 66</u> 19 to <u>4. 21</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4. 21</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
 | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
<u>GRUMBERG IOSEF</u> | | | | 23D. ADDRESS
<u>Lutheran Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/25/1966</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Woodlawn Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Woodlawn, Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 25 1966</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR
<u>Wm. J. Fickner & Sons with Pa.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-----------------------|--|--|---|--|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>66 04183</u> | | | | |
| BIRTH NO. <u>66 04183</u> | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Earl E. Carrick</u> | | | | | 2. DATE AND HOUR OF DEATH
<u>April 23, 1966 4 45 P.M.</u> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MD</u> B. COUNTY <u>12-05</u> | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Maryland General Hosp</u> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTO</u> | | | | |
| D. STREET ADDRESS (If rural, give location)
<u>2024 N. Charles St</u> | | | | | | | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>Col</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>DIVORCED</u> | 8. DATE OF BIRTH
<u>March 4, 1902</u> | 9. AGE (In years last birthday)
<u>64</u> | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Painter Construction</u> | | 11. BIRTHPLACE (State or foreign country)
<u>BALTO MD</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | |
| 13. FATHER'S NAME
<u>Benjamin A. Carrick</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary R. Laughlin</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | | | 16. SOCIAL SECURITY NO.
<u>219-03-2572</u> | | 17. INFORMANT
<u>Ralph R. Carrick</u> ADDRESS <u>5217 Wilton Heights AVE Baltimore, Md. 15</u> | | |
| 18. <u>3-21-0 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
<u>BILONCHUPNEUMONIA, CONFLUENT</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>PORTAL CIRRHOSIS</u> | | | | | CAUSE OF DEATH
<u>BILONCHUPNEUMONIA, CONFLUENT</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>17/19/66</u> | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>Pneumonia Empty Sema</u> | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>Yes</u> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/23</u> 19 <u>66</u> to <u>4/23</u> 19 <u>66</u> that (I) <u>last</u> saw the deceased alive on <u>4/23</u> 19 <u>66</u> and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<u>Ronald T. Lewis</u> M.D. | | | | | 23B. DATE SIGNED
<u>4-23-66</u> | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS
M.D. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/26/1966</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Lorraine Park Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Woodlawn, Maryland</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 25 1966</u> | | 25B. NAME OF REGISTRAR
<u>Ralph E. Carrick</u> | | 25C. FUNERAL DIRECTOR
<u>Wm. J. Tichner</u> ADDRESS <u>BALTO, MD. NORTH AVE.</u> | | | | | |

CELESTION MEMOIR DE

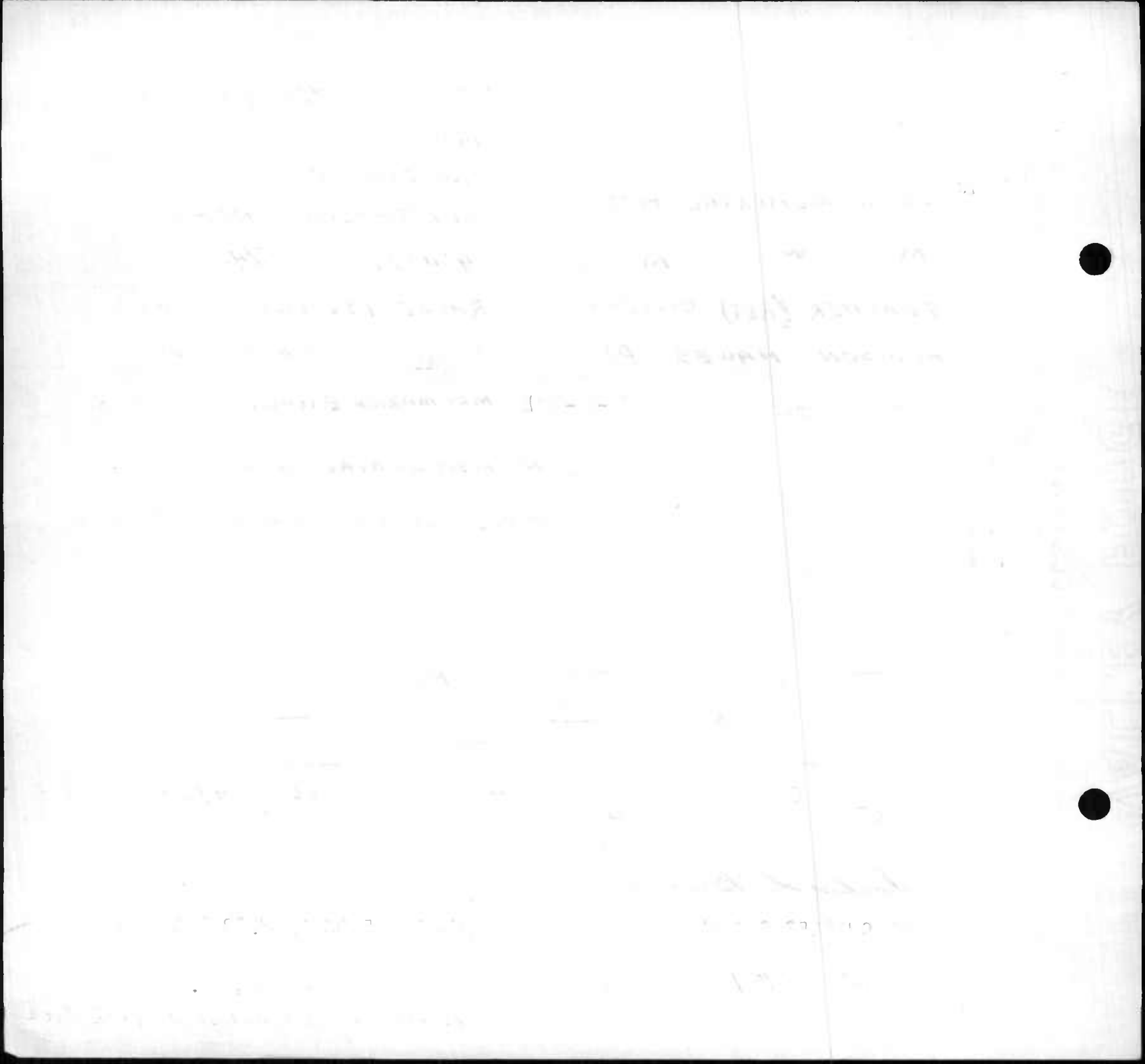
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 04184</u> | |
|--|---------------------|---|------------------------------------|--|---|
| BIRTH NO. <u>66 04184</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>HAWES, RAYMOND PRESTON</u> | | 2. DATE AND HOUR OF DEATH
<u>4/23/66</u> <u>9</u> ^{<u>28</u>} _{<u>A</u>} M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>UNION MEMORIAL HOSP</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MD.</u> B. COUNTY <u>27-12</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>
D. STREET ADDRESS (If rural, give location) <u>319 TAPLOW ROAD</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>4/11/91</u> | 9. AGE (In years last birthday) <u>75</u> ^{<u>XX</u>} _{<u>XX</u>} | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>TEACHER (RET)</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>COLLEGE</u> | | 11. BIRTHPLACE (State or foreign country)
<u>RHODE ISLAND</u> | |
| 13. FATHER'S NAME
<u>ADDISON HAWES (D)</u> | | 14. MOTHER'S MAIDEN NAME
<u>Ella JENCKS (D)</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>Yes</u> <u>World I</u> | | 16. SOCIAL SECURITY NO.
<u>220-30-3724</u> | | 17. INFORMANT
<u>MRS MARION E. HAWES</u> ADDRESS <u>SAME</u> | |
| 18. <u>420.1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>ANTECEDENT CAUSES</u>
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH
(A) <u>AC. MYOCARDIAL INFARCT</u> DUE TO
(B) <u>CONGESTIVE HEART FAILURE</u> DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>20 DAYS</u>
<u>20 DAYS</u> | |
| 19A. DATE OF OPERATION
<u>0</u> _____ | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
_____ | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____ | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? _____ | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <u>4/3</u> 19 <u>66</u> to <u>4/23</u> 19 <u>66</u> , that (I) <u>we</u> lost saw the deceased alive on <u>4/23</u> 19 <u>66</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Charles S. Brown</u> M.D. | | | | 23B. DATE SIGNED
<u>4/23/66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>DR CHARLES S BROWN</u> | | | | 23D. ADDRESS
<u>UNION MEMORIAL HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Cremation</u> | | 24B. DATE
<u>4/23/66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Loudon Park</u> | |
| 24D. LOCATION
<u>Baltimore, Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 25 1966</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>William J. Zuckewski Sons & Partners</u> | | | |



1
C 464

66 04185

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04185

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Cesario CLARELLI

2. DATE AND HOUR PRONOUNCED DEAD

4/24/1966 8.20 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

107 Albemarle str.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTO.

D. STREET ADDRESS (If rural, give location)

107 ALBEMARLE ST.

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

NOV. 1 1887

9. AGE (In years
last birthday)

88 89

10. Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

BRICKLAYER

10B. KIND OF BUSINESS OR INDUSTRY

RETIRED

11. BIRTHPLACE (State or foreign country)

ITALY

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

CESARIO CLARELLI

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

090-07-2632

17. INFORMANT

ADDRESS

MRS MARY CLARELLI 107 ALBEMARLE

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-24-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

4/26/66

23C. NAME of CEMETERY or CREMATORY

ST, RAYMONDS BRONZ N.Y.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 25 1966

24B. NAME OF REGISTRAR

Robert E. Stanley, M.D.

24C. FUNERAL DIRECTOR

Frank Della Noce

322 S. HIGH ST

WALLACE BOYD
PRESIDENT

1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>66 04186</u> | |
|--|-------------------------|---|-----------------------------------|--|---|--|--|
| BIRTH NO. <u>66 04186</u> | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>WISE ALICE B.</u> | | | | 2. DATE AND HOUR OF DEATH
<u>4. 22 1966</u> | | <u>7 15</u> A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Lutheran Hospital of Maryland</u> | | (If not in hospital or institution, give street address or location) | | A. STATE
<u>MARYLAND</u> | | B. COUNTY
<u>16-06</u> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>2817 RAYNER AVE 21216</u> | | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>2/5/03</u> | 9. AGE (In years last birthday)
<u>63</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>HOME</u> | | 11. BIRTHPLACE (State or foreign country)
<u>BALTO. MD</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<u>WILLIAM BRADY</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>ALICE COSTLEY</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>MR. FREDERICK BRADY</u>
<u>2817 RAYNER AVE.</u> | | | |
| 18. <u>463X1</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Heart Failure</u> | | | | CAUSE OF DEATH
(A) <u>Thrombophlebitis - right leg</u>
DUE TO
(B) <u>Heart Failure</u>
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3. 27</u> 19 <u>66</u> to <u>4. 22</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4. 22</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>[Signature]</u> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>4/22/66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>GRUMBERG LOSEF</u> | | | | 23D. ADDRESS
M.D. <u>Lutheran Hospital</u> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/20/66</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Mt. Auburn</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Balt. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 25 1966</u> | | 25B. NAME OF REGISTRAR
<u>[Signature]</u> | | 25C. FUNERAL DIRECTOR
<u>[Signature]</u> | | ADDRESS
<u>1631 N. Hill Ave</u> | |

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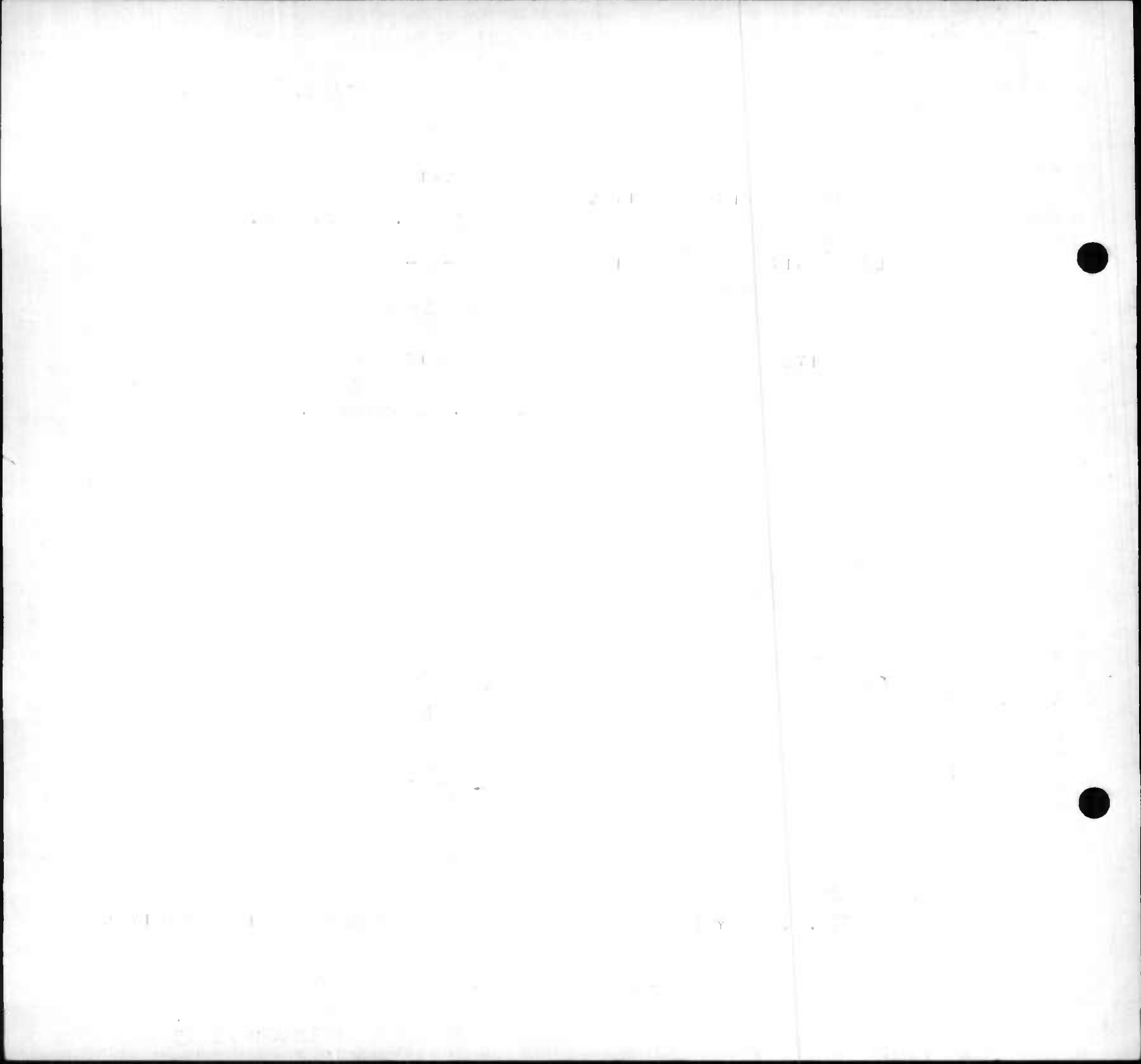
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1917

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|---|---|--|--|---|---|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>66 04187</u> | | | | |
| BIRTH NO. <u>66 04187</u> | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>NORA BLESSING</u> | | | | | 2. DATE AND HOUR OF DEATH <u>4/23/66</u> <u>6:30</u> <u>P</u> M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>THE JOHNS HOPKINS HOSPITAL</u> | | | | | A. STATE <u>MARYLAND</u> | | | | |
| | | | | | B. COUNTY | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
<u>1742 E. NORTH AVE.</u> | | | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | | 8. DATE OF BIRTH
<u>9-10-84</u> | 9. AGE (In years last birthday)
<u>81</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>at Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>GEORGE LITZ</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>SUSIE CARR</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | | 16. SOCIAL SECURITY NO.
<u>213 12 8593 B.</u> | | 17. INFORMANT ADDRESS
<u>1742 East North Avenue</u>
<u>Mr. Clarence H. Blessing</u> | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Hypercalcemia</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>7 days</u> | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Carcinoma colon</u> | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>4/22</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Carcinoma colon</u> | | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>No</u> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>4/12</u> 19 <u>66</u> to <u>4/23</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6:30 P.</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<u>B.K. Gray</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
<u>4/23/66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>B.K. GRAY</u> | | | | | 23D. ADDRESS
<u>THE JOHNS HOPKINS HOSPITAL</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/26/66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Parkwood Cemetery</u> | | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore Maryland</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 25 1966</u> | | | 25B. NAME OF REGISTRAR
<u>Robert E. Farley</u> | | | 25C. FUNERAL DIRECTOR ADDRESS
<u>HENRY SANDER & SONS INC.</u>
<u>BALTIMORE MARYLAND 21213</u> | | | |



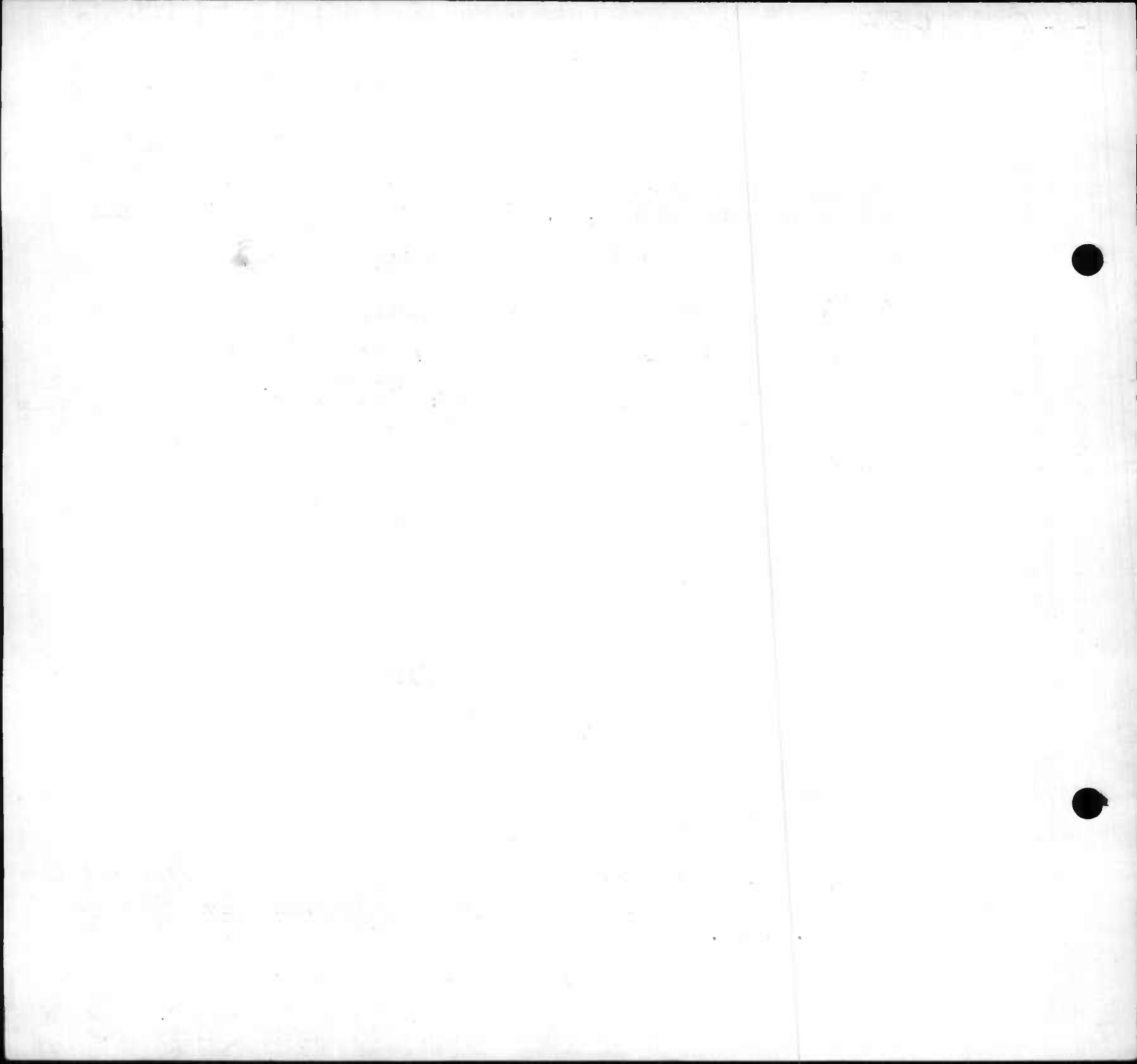
40-04-84
FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 04188 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04188 | |
|--|---------------------|---|--------------------------------------|---|---|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) CARRIE Dehring | | | | 2. DATE AND HOUR OF DEATH
4-22-66 7²⁰ A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
BALTO City Hosp 21224
4940 Eastern Avenue Baltimore, Md. | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MD B. COUNTY BALTO.
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO
D. STREET ADDRESS (If rural, give location) 2306 FLEET St - 21224 | | | |
| 5. SEX
Female | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
8-16-1881 | 9. AGE (In years last birthday)
84 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
ASSORTER | | 10B. KIND OF BUSINESS OR INDUSTRY
GOOD WILL INC. | | 11. BIRTHPLACE (State or foreign country)
Maryland, Baltimore | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
MARTIN Dehring | | | | 14. MOTHER'S MAIDEN NAME
MARY Meyer | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
212-32-3033 | | 17. INFORMANT Mrs Harry J. Dehring ADDRESS 21224
BCH: Med Record 4940 Eastern Avenue | | | |
| 18. 422.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
CHRONIC BRAIN SYND
INTERVAL BETWEEN ONSET AND DEATH 4 YEARS
ASCVD
4 YEARS
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that it (this hospital) attended the deceased from 6-5 19 64 to 4-22 19 66 , that it (we) last saw the deceased alive on 4-22 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. it (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
J E Randall M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4-22-66 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. John E. Randall | | | | 23D. ADDRESS
4940 Eastern Avenue 21224
BALTO CITY HOSP. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/25/66 | | 24C. NAME of CEMETERY or CREMATORY
Baltimore Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | 25B. NAME OF REGISTRAR
Robert E. Fisher | | 25C. FUNERAL DIRECTOR
HENRY SANDER & SONS INC.
BALTIMORE MARYLAND 21213 | | | |



66 04189

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 04189

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Kathryn Weston

2. DATE AND HOUR OF DEATH

4-12-66 11:25 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street
address at location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

861 Hollins Street

21201

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)
Never Married

8. DATE OF BIRTH

5-25-1891

9. AGE (In years
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Simeon Weston

14. MOTHER'S MAIDEN NAME

Hannah

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue

21224

18. 609X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Respiratory arrest

(B) DUE TO

Sepsis

(C) DUE TO

Urinary tract infection

INTERVAL BETWEEN
ONSET AND DEATH

4 day

2 mos

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (nailly medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 3-30-1966 to 4-12-1966,
that (1) (we) last saw the deceased alive on 4-12-1966 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Joel F. Habener

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

4-12-1966

23C. PHYSICIAN'S
NAME (Type)

Joel F. Habener

23D. ADDRESS

M.D. 4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

APR 25 1966

24C. NAME OF CEMETERY

ANATOMIC BOARD OF MARYLAND

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 25 1966

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

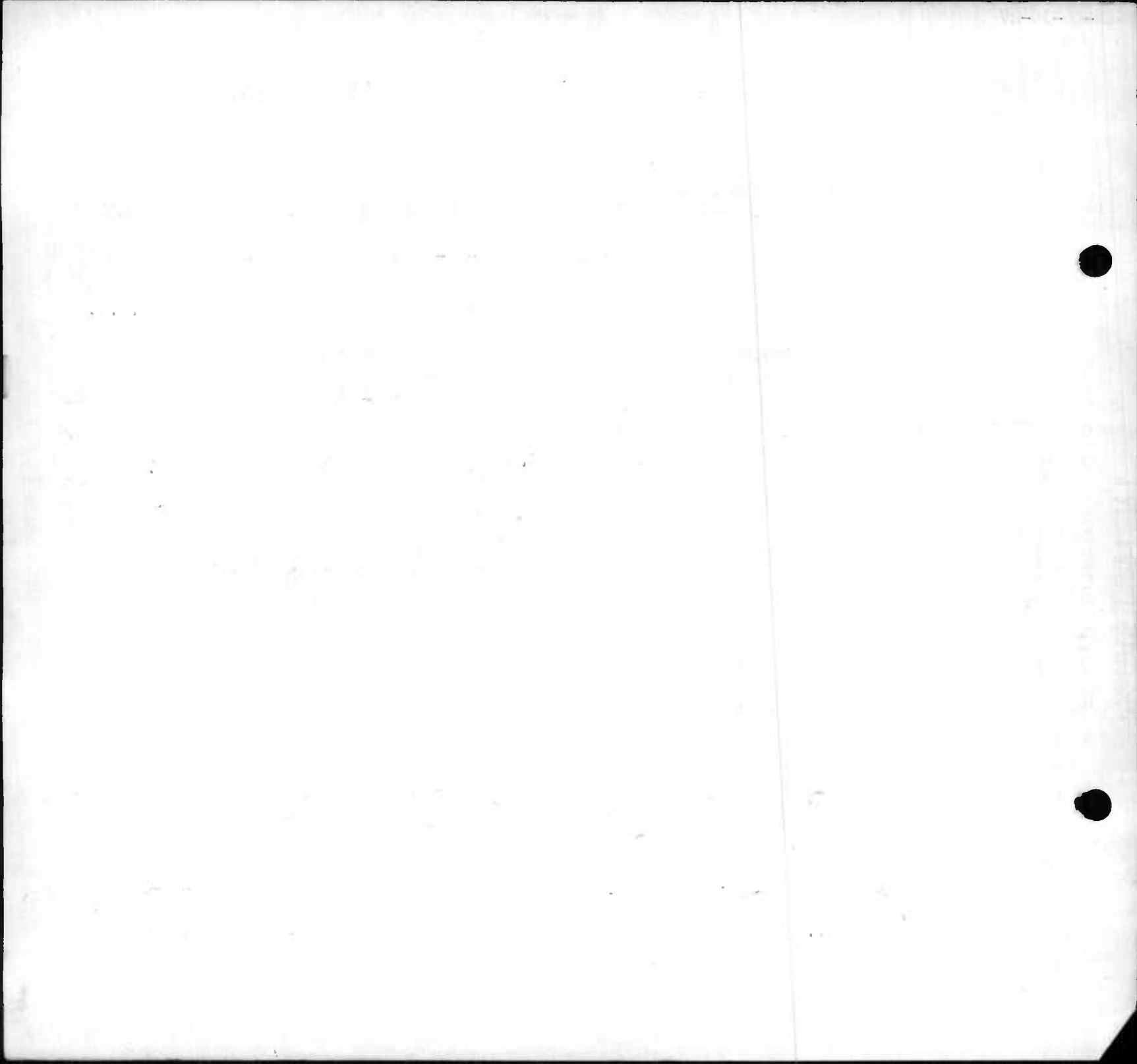
25C. FUNERAL DIRECTOR

UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

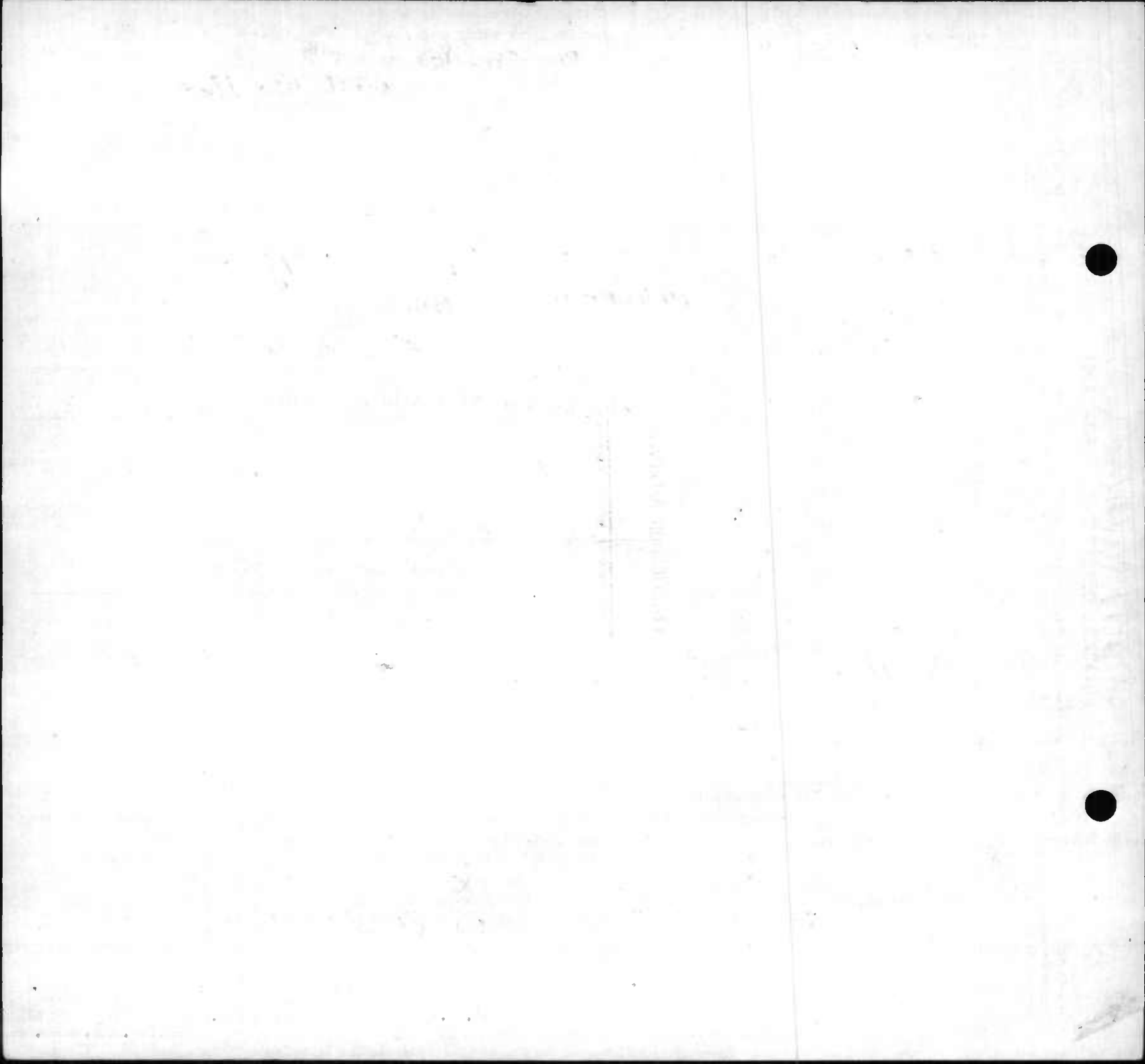
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



ON APPROVAL
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------|--|--------------------------|--|--|
| BIRTH NO. 66 04190 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04190 | |
| M.E. CASE NO. OWEN PEALE WEATHERED OWINGS | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| | | APRIL 23, 1966 9:15 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| 44 UNION MEMORIAL HOSPITAL | | MARYLAND | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 630 WYANOKE AVE. WYANOKE | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, <u>DIVORCED</u> (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min. |
| MALE | WHITE | | 10/21/94 | 71 years | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| INSURANCE HELPER | | INSURANCE | | BALTIMORE CITY | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| SAMUEL S. OWINGS | | | ELIZA YATES WETHERED | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| YES | | WORLD WARI BY 213-166558-A | | MISS MARY CLARK (NIECE) | |
| | | | | ADDRESS P.O. B. 202 ELLICOTT CITY, MD. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | (A) Anteroseptal Heart Disease | | | |
| ANTECEDENT CAUSES | | (B) Stokes-Adams Attack | | | |
| DISEASES OR CONDITIONS, if any, give rise to the above cause (A) stating UNDERLYING CONDITION lost. | | (C) Failure Pace-maker Battery | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) | |
| 1/11/63 | | Stroke-Adams Attack | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (APPROX.) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| P. Attar | | | | April 23, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| SAFUR ATTAR | | M.D. UNIVERSITY HOSP. BALTIMORE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 4/26/1966 | | St. John's | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Ellicott City, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| APR 25 1966 | | Robert E. Farley, M.D. | | H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md. | |

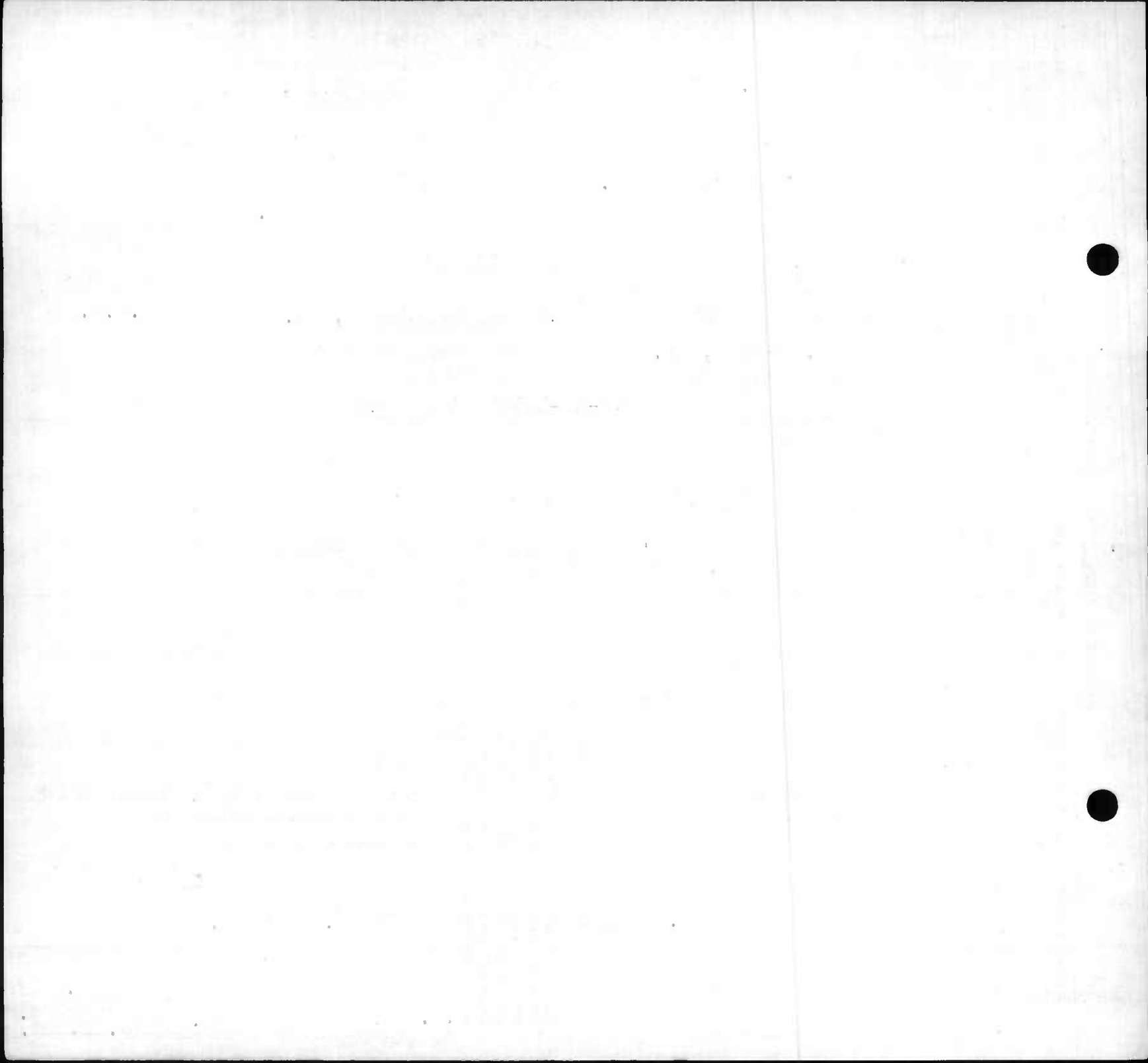


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 04191 | |
|---|----------------------|---|--------------------------------------|--|---|
| BIRTH NO.
66 04191 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print)
W. Ullrich Warner | | 2. DATE AND HOUR OF DEATH
April 24, 1966 18:30 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

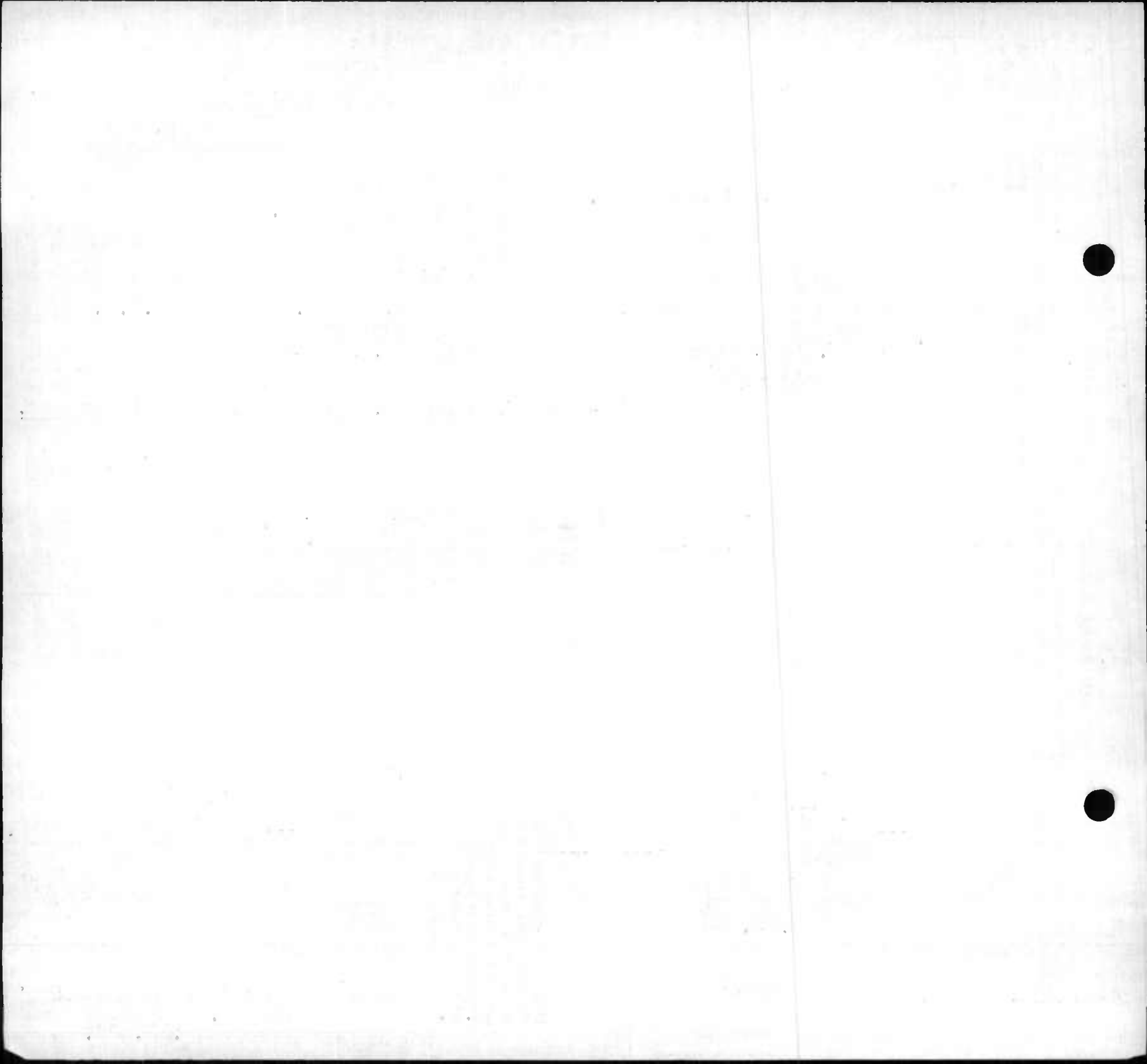
FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
2920 Wyman Pkwy. | | 4. USUAL RESIDENCE (Where deceased lived. (If institution: residence before admission)
A. STATE
Maryland
B. COUNTY
12-06
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2920 Wyman Pkwy. | | | |
| 5. SEX
M | 6. RACE
W. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never Married | 8. DATE OF BIRTH
11/5/1887 | 9. AGE (In years last birthday)
78 | If Under 1 Yr. Months: Days
If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Executive | | 10B. KIND OF BUSINESS OR INDUSTRY
Banking | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | |
| 13. FATHER'S NAME
Francis A. Warner, Jr. | | 14. MOTHER'S MAIDEN NAME
Emma Ullrich | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WWI | | 16. SOCIAL SECURITY NO.
217-14-1116A | | 17. INFORMANT
Miss Emma Warner | |
| | | | | ADDRESS
(Same) | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
acute coronary insufficiency | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
1 day | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
coronary sclerosis | | (B) coronary sclerosis | | 7+ yrs | |
| | | (C) old myocardial infarction (1958) | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1958 19 to 4/24 19 66 , that (I) (we) last saw the deceased alive on 4/11 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
William F. Renner | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/25/66 | |
| 23C. PHYSICIAN'S NAME (Type)
William F. Renner | | 23D. ADDRESS
3222 St. Paul St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/27/1966 | | 24C. NAME of CEMETERY or CREMATORY
Greenmount | |
| 24D. LOCATION
Baltimore | | 24E. STATE
Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | 25B. NAME OF REGISTRAR
C. E. & E. Jenkins | | 25C. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. | |
| | | | | ADDRESS
4905 York Rd. Balto. 12, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Baltimore City Health Department | |
|---|---------|--|---|--|-----------------------------|
| 66 04192 | | | | Registered No. 66 04192 | |
| BIRTH NO. | | | | M.E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| Sarah Roberta Mackenzie | | | April 21, 1966 6:20a.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| 804 Evesham Ave. | | | Maryland 27-48 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | | Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 804 Evesham Ave. | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. UNDER 1 Yr. Months Days |
| F | W | Widowed | 2/9/1878 | 88 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | Own Home | | Belair, Md. | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| George Y. Maynadier | | | U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| No | | | 216-46-6751 | | |
| 17. INFORMANT | | | ADDRESS | | |
| Robert H. Mackenzie, 804 Evesham Ave. | | | | | |
| 18. CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | (A) DUE TO | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | Coronary Thrombosis 2 Hours | | |
| ANTECEDENT CAUSES | | | (B) DUE TO | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | Arteriosclerosis 15 Years | | |
| II | | | (C) DUE TO | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | None | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| None | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from March 15 1940 to April 21 1966, that (I) (we) last saw the deceased alive on April 19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| A.S. Chalfant M.D. | | | | 4/21/1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| A. S. Chalfant M.D. | | | | 6210 York Road | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 4/23/1966 | | Christ Church | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| APR 25 1966 | | H.W. Jenkins & Sons Co. | | 4905 York Road Balto. 12, Md. | |



FUNERAL DIRECTOR: IMPORTANT

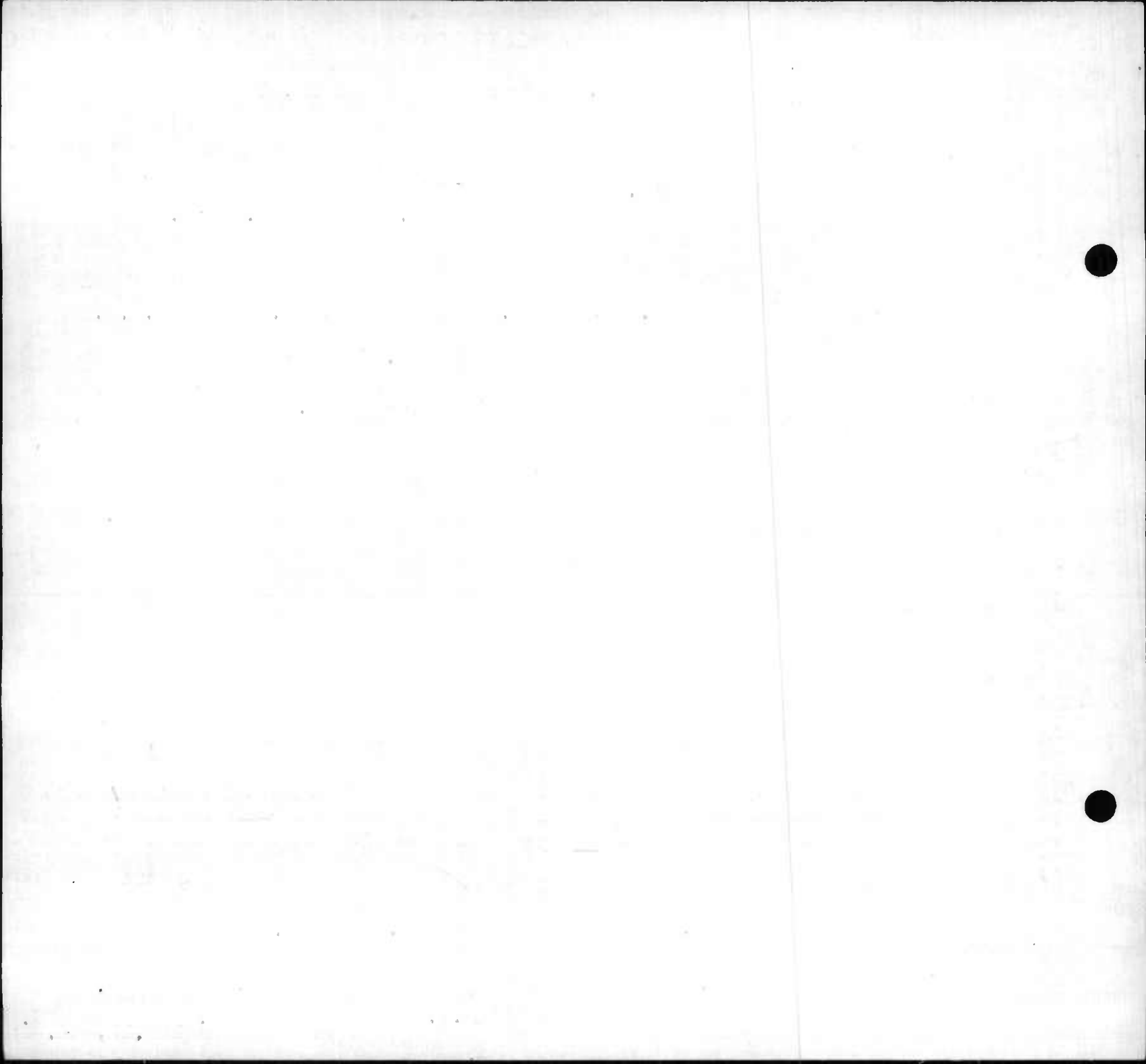
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>66 04193</u> | |
|--|---------------------|---|--|---|--|--|--|
| BIRTH NO. <u>66 04193</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Frances H. Ryan</u> | | 2. DATE AND HOUR OF DEATH
<u>April 21, 1966</u> <u>10:30</u> P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Preston Apts.</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY <u>1101</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>
D. STREET ADDRESS (If rural, give location) <u>218 E. Preston St. (Apt. 2D)</u> | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Never Married</u> | | 8. DATE OF BIRTH
<u>9/23/1898</u> | 9. AGE (In years last birthday)
<u>67</u> | 10. If Under 1 Yr. If Under 24 Hrs.
Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Clerk-Retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Balto. Transit Co.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Lanty Ryan</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary A. O'Brien</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Miss Margaret E. Ryan</u> | | ADDRESS
<u>(Same)</u> | |
| 18. <u>420.11</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) <u>Coronary thrombosis</u>
DUE TO
(B) <u>Arteriosclerosis C-V disease</u>
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>1/2 hr.</u>
<u>5 yrs.</u> | |
| | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initally medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>42</u> to <u>April 21</u> 19 <u>66</u> . that (I) (two) last saw the deceased alive on <u>April 6</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (two) (<u>did</u>) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>W. H. Grenzer</u> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>4.22.66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>William H. Grenzer</u> | | | | 23D. ADDRESS
M.D. <u>1520 E. 33rd St.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/25/1966</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>New Cathedral</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 25 1966</u> | | 25B. NAME OF REGISTRAR
<u>W. H. Grenzer</u> | | 25C. FUNERAL DIRECTOR
<u>H. W. Jenkins & Sons Co.</u>
ADDRESS
<u>4905 York Rd. Balto. 12, Md.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>66 04194</u> | |
|---|----------------------|---|---------------------------------|--|----------------------------|---|-----------------------------|
| BIRTH NO. <u>66 04194</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED <u>JONES NELLIE BIAYS</u> | | 2. DATE AND HOUR OF DEATH <u>4-24-66</u> <u>3³⁰ P.</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>CHURCH HOME AND HOSPITAL</u>
<u>BALTIMORE, MARYLAND 21231</u> | | | | A. STATE <u>MARYLAND</u> B. COUNTY <u>6-05</u> | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>CHURCH HOME & HOSPITAL</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>WIDOWED</u> | 8. DATE OF BIRTH <u>5-25-78</u> | 9. AGE (In years last birthday)
<u>87</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>NONE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>NONE</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>United States</u> | |
| 13. FATHER'S NAME
<u>THOMAS I JONES</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>MARY B. JONES</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>-</u> | | 17. INFORMANT
<u>Mrs. Colston Young</u> | | ADDRESS
<u>5818 MEADOWOOD RD</u>
<u>21212</u> | |
| 18. <u>43001</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Pulmonary edema</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Atherosclerosis</u> | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No)
<u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4-20</u> 19 <u>66</u> to <u>4-24</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4-20</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>R. A. Nahum</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>4-24-66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>DR. R. NAHUM</u> | | | | 23D. ADDRESS
<u>Church Home & Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/26/1966</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Loudon Park</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 25 1966</u> | | 25B. NAME OF REGISTRAR
<u>R. E. Jenkins</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u> | | | |

BALTIMORE HAYLAND 2131
CHURCH ROAD AND HOSPITAL

2-12-48 15

9 WHITE MIDOW

HAYLAND

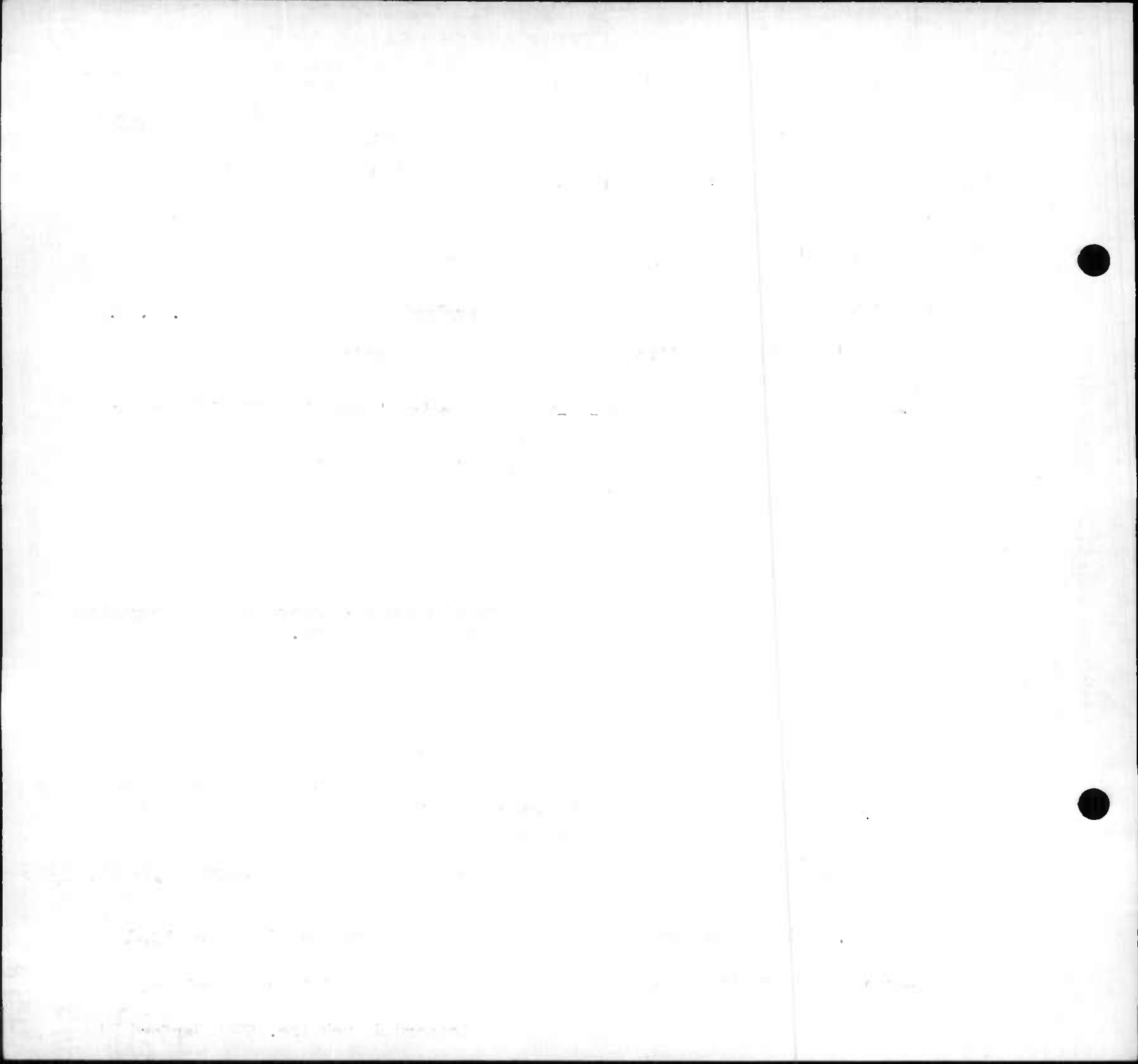
NO 21

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

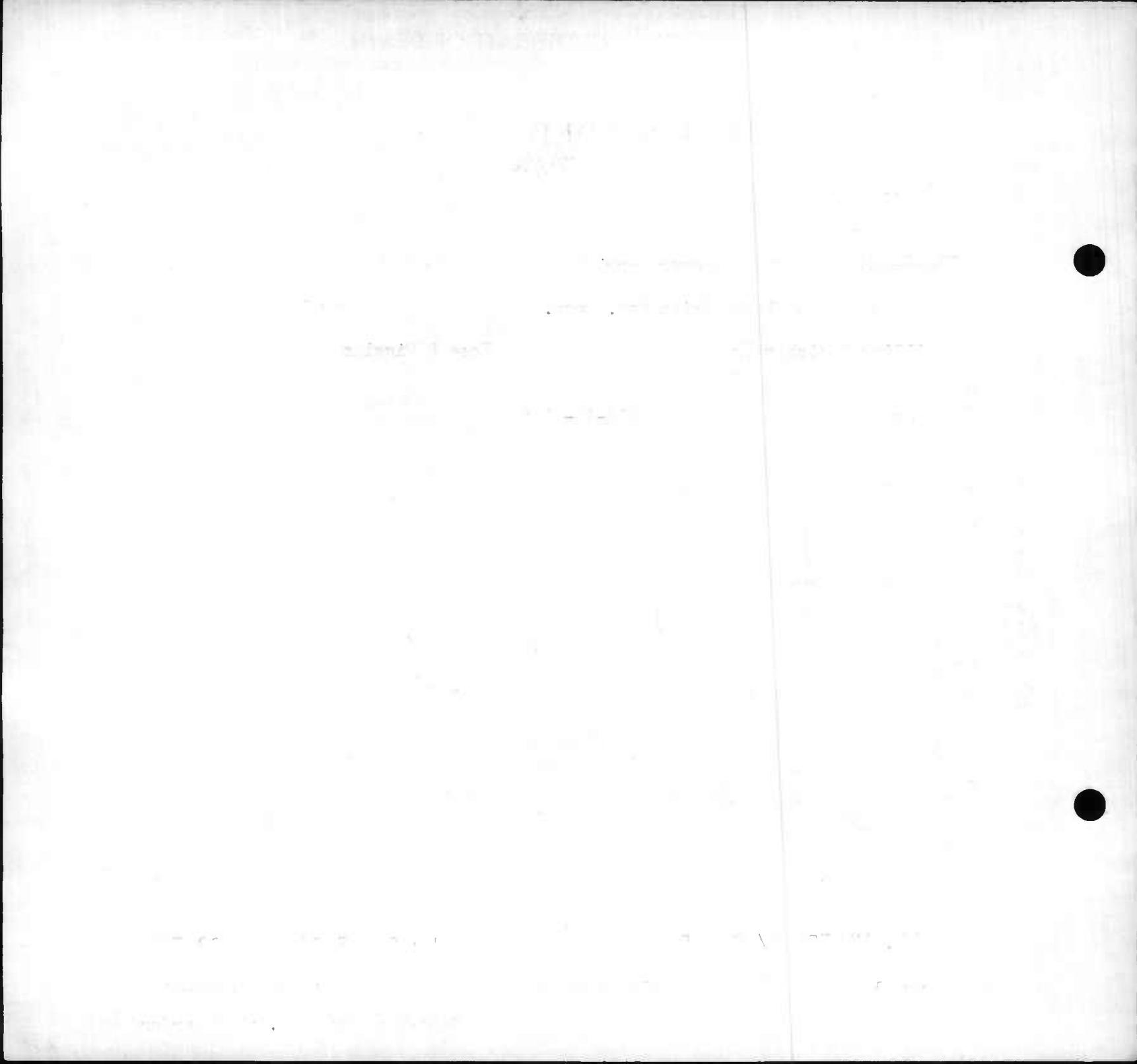
| BIRTH NO. 66 04195 | | BALTIMORE CITY HEALTH DEPARTMENT | | REGISTERED NO. 66 04195 | |
|--|------------------|---|---|--|--|
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) MARGARET O'LAUGHLIN | | | 2. DATE AND HOUR OF DEATH
4-24-66 7 AM M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
33 THE JOHNS HOPKINS HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
5404 GERLAND AVENUE | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOW | 8. DATE OF BIRTH
3-13-92 | 9. AGE (In years
lost birthday)
74 | 10. Under 1 Yr. Months: Days
11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland |
| 13. FATHER'S NAME
FREDERICK XXXXXX Witte | | | 14. MOTHER'S MAIDEN NAME
? Annie Zapp | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
216-28-3629 | | 17. INFORMANT ADDRESS
Mr Louis O'Loughlin 2513 Hillford Dr # 34 |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. If means the disease, injury or complication which caused death.)
4-20-1 I
Myocardial infarction
HASCVD | | | INTERVAL BETWEEN ONSET AND DEATH
2 days
years | | |
| 18. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Cerebral hypoxic damage secondary to cardiac arrest 2 days before death. | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Apr 22 1966 to Apr 22 24 1966, that (I) (we) lost saw the deceased alive on April 24 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
W. Leigh Thompson | | | 23B. DATE SIGNED
Interne Apr 24, 1966 | | |
| 23C. PHYSICIAN'S NAME (Type)
W. Leigh Thompson | | | 23D. ADDRESS
Osler: Johns Hopkins Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/27/66 | | 24C. NAME OF CEMETERY or CREMATORY
Parkwood | |
| 24D. LOCATION
Baltimore Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
Leonard J Ruck Inc. 5305 Harford Rd | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04196 | |
|--|----------------------|---|--|---|---|
| BIRTH NO. | | 66 04196 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print) MARIE R. FISHER | | | 2. DATE AND HOUR OF DEATH
4/23/66 9 A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
CERTIFICATE AMENDED
HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSP. address or location 4/9/66 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 1521 East Preston St. | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) Never Married | 8. DATE OF BIRTH
9/1/06 | 9. AGE (In years last birthday) 59 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Telephone Clerk | | | 10B. KIND OF BUSINESS OR INDUSTRY
Union Mem. Hosp. | | 11. BIRTHPLACE (State or foreign country)
USA Maryland |
| 13. FATHER'S NAME
William H Fisher Sr | | | 14. MOTHER'S MAIDEN NAME
Rose M Diggins | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
212-12-7125 | | 17. INFORMANT
Lillian Politt ADDRESS
282-1384 |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
422.1 I
Uremia
ASCVD P.H. | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH
8 months | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Pericarditis P.H. acute. | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/23/66 19 to 4/23/66 19 that (I) (we) last saw the deceased alive on 4/23/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Walter T. Boone M.D. | | | | 23B. DATE SIGNED
4/23/66 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. WALTER T. BOONE | | | | 23D. ADDRESS
UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/27/66 | | 24C. NAME OF CEMETERY or CREMATORY
Holy Redeemer | |
| 24D. LOCATION
Baltimore Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | | |
| 25B. NAME OF REGISTRAR
P. E. E. Farley | | 25C. FUNERAL DIRECTOR
Leonard J Ruck Inc. 5305 Harford Rd | | | |



66 04197

BALTIMORE CITY HEALTH DEPARTMENT

66 04197

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

George E. NOYES

2. DATE AND HOUR PRONOUNCED DEAD

4/24/66

1.10 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hosp. (DOA)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3308 Grenton Ave

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

July 20, 1907

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Claim Examiner

10B. KIND OF BUSINESS OR INDUSTRY

State Of Md.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Charles Noyes

14. MOTHER'S MAIDEN NAME

Elizabeth Lloyd

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW 11

16. SOCIAL
SECURITY NO.

212-14-0544

17. INFORMANT

ADDRESS

Mrs Etta H. Black 3308 Grenton Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-24-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/27/66

23C. NAME OF CEMETERY or CREMATORY

Loudon Park

23D. LOCATION

(City, town, or county)

Baltimore

Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 25 1966

24B. NAME OF REGISTRAR

Rudiger E. Breitenecker

24C. FUNERAL DIRECTOR

Leonard J Ruck Inc. 5305 Harford Rd.

ADDRESS

U. S. A.

2000 Canton Ave

Belmont

Massachusetts

July 20, 1902

Dear Sir,

27 South Street

215-14-0000, Mr. John H. Black 2000 Canton Ave

WATERBURY CIRCLE

John H. Black

27 South Street

Belmont, Mass.

John H. Black

Belmont

August 1, 1902

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | | | BALTIMORE CITY HEALTH DEPT. | | | | Registered No. | | | |
|--|--|--|--|--|--|--|--|---|--|--------------------------------|--|
| 66 04198 | | | | 66 04198 | | | | 66 04198 | | | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | | M. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 4-24-66 | | | | 525A | | | |
| JAMES E YOWELL | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | | A. STATE
BALTIMORE | | | | B. COUNTY
6-01 | | | |
| THE JOHNS HOPKINS HOSPITAL
601 N. BROADWAY 21205 | | | | C. CITY OR TOWN
MARYLAND | | | | D. STREET ADDRESS
(If rural, give location) | | | |
| 135 N. KENWOOD AVENUE 21224 | | | | | | | | | | | |
| 5. SEX
MALE | | 6. RACE
WHITE | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
Sept. 27, 1886 | | 9. AGE (In years last birthday)
78 79 | | 10. If Under 1 Yr. Months Days | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Carpenter | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | |
| 13. FATHER'S NAME
JOHN YOWELL | | | | 14. MOTHER'S MAIDEN NAME
JULIA BEASLEY | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs Gertrude Yowell 135 N. Kenwood Ave | | | | ADDRESS | |
| 18. 5-27-21
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, pneumonia, etc. It means the disease, injury or complication which caused death.)
CHRONIC PULMONARY DISEASE | | | | CAUSE OF DEATH
CHRONIC PULMONARY DISEASE | | | | INTERVAL BETWEEN ONSET AND DEATH
YEARS | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
ARTERIO SCLEROTIC CARD-VASCULAR DISEASE | | | | | | | | YEARS | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (H) (this hospital) attended the deceased from APR 14, 1966 to APR 24, 1966
that (H) (we) last saw the deceased alive on APR 24, 1966 and that in (M) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Rainer M. Engel | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
4-24-66 | | | |
| 23C. PHYSICIAN'S NAME (Typed)
RAINER M. ENGEL | | | | 23D. ADDRESS
601 N. BROADWAY 21205
JOHNS HOPKINS HOSPITAL, BALTO | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/27/66 | | 24C. NAME OF CEMETERY or CREMATORY
Moreland Memorial | | 24D. LOCATION
(City, town, or county) (State)
Baltimore Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | | | 25B. NAME OF REGISTRAR
Robert E. Vasey | | | | 25C. FUNERAL DIRECTOR
Leonard J Ruck Inc 5305 Harford Rd | | | |

4-24-66 2nd

CHRONIC PULMONARY DISEASE

YES

ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE

YES

APR 24

APR 24

APR 24

APR 24

4-24-66

X

JOHN HOPKINS HOSPITAL, BALTO

RAINER M. ENGER

[Signature]

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHRISTOPHER E. SCHEMM

2. DATE AND HOUR PRONOUNCED DEAD

4-24-66

7:40 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3212 Woodhome Avenue 21234

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 8, 1903.

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Police

10B. KIND OF BUSINESS OR INDUSTRY

Balto. Police Dept.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Peter J. Schemm

14. MOTHER'S MAIDEN NAME

Mary Ward

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.
220-44-0635

17. INFORMANT

Mrs. Anna Schemm

ADDRESS

(Same)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-25-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/28/66.

23C. NAME OF CEMETERY or CREMATORY

Parkwood Cemetery

23D. LOCATION

(City, town, or county) (State)
Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 25 1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Balto. Md. 21214

ADDRESS

WALL
FAS CONTENT
FORCE

Woolman
Woolman

Nov. 8, 1907.

Woolman

Woolman

Woolman, John, Jr.

Woolman, John, Jr.

Woolman, John, Jr.

Woolman, John, Jr.

Woolman

Woolman, John, Jr.

Woolman, John, Jr.

Woolman

Woolman

Woolman, John, Jr.

FUNERAL DIRECTOR: IMPORTANT

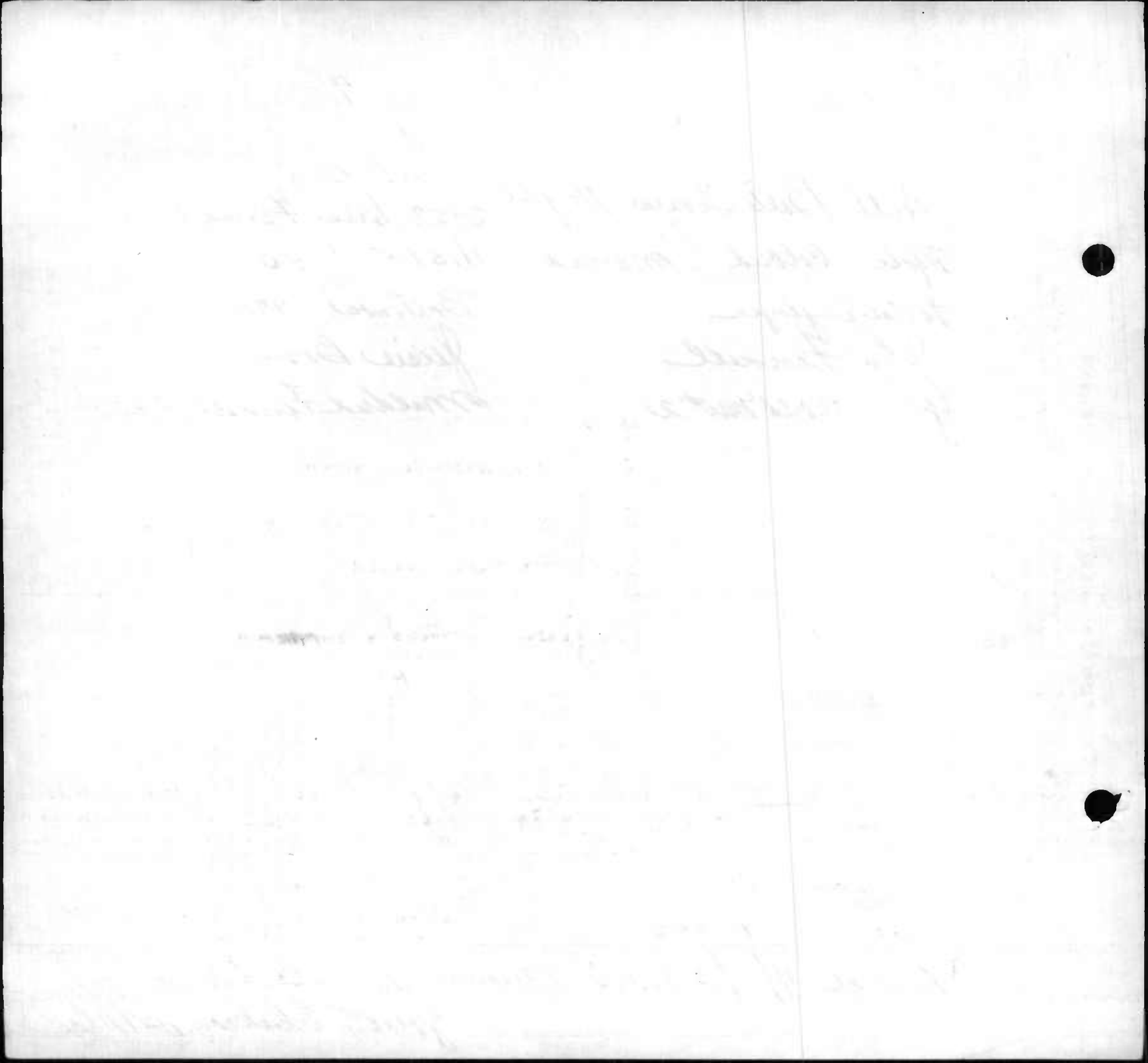
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|--|---|---|
| BIRTH NO. 66 04200 | | CERTIFICATE OF DEATH | | Registered No. 66 04200 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) WHEELER, Merritt Leland | | 2. DATE AND HOUR OF DEATH
4/25/66 1255 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY none | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
3120 Northern Parkway | | D. STREET ADDRESS (If rural, give location)
3120 Northern Parkway | | | |
| 6. SEX
male | 7. RACE
white | 8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
married | 9. DATE OF BIRTH
April 8, 1886 | 10. AGE (In years last birthday)
80 | 11. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
clerk | | 10B. KIND OF BUSINESS OR INDUSTRY
U.S. Postoffice | | 11. BIRTHPLACE (State or foreign country)
Dryden, N.Y. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
DeWitt Thurston Wheeler | | 14. MOTHER'S MAIDEN NAME
Carrie E. Gaston | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220-48-5174 | | 17. INFORMANT
Mrs. Elsie L. Dryden--3120 Northern Parkway | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
442X1 | | CAUSE OF DEATH
(A) Renal failure
(B) Arteriosclerotic Cardiovascular disease
(C) Nephrosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
1 week
many years | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Parkinson's disease | | many years | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 4/21 19 66 to 4/25 19 66 , that (I) (we) last saw the deceased alive on 4/21 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Hans Koetter | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/25/66. | |
| 23C. PHYSICIAN'S NAME (Type)
HANS J. KOETTER | | 23D. ADDRESS
5600 HARFORD ROAD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/28/66. | | 24C. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | 25B. NAME OF REGISTRAR
Robert E. Johnson | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc.--5305 Harford Road, 14 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

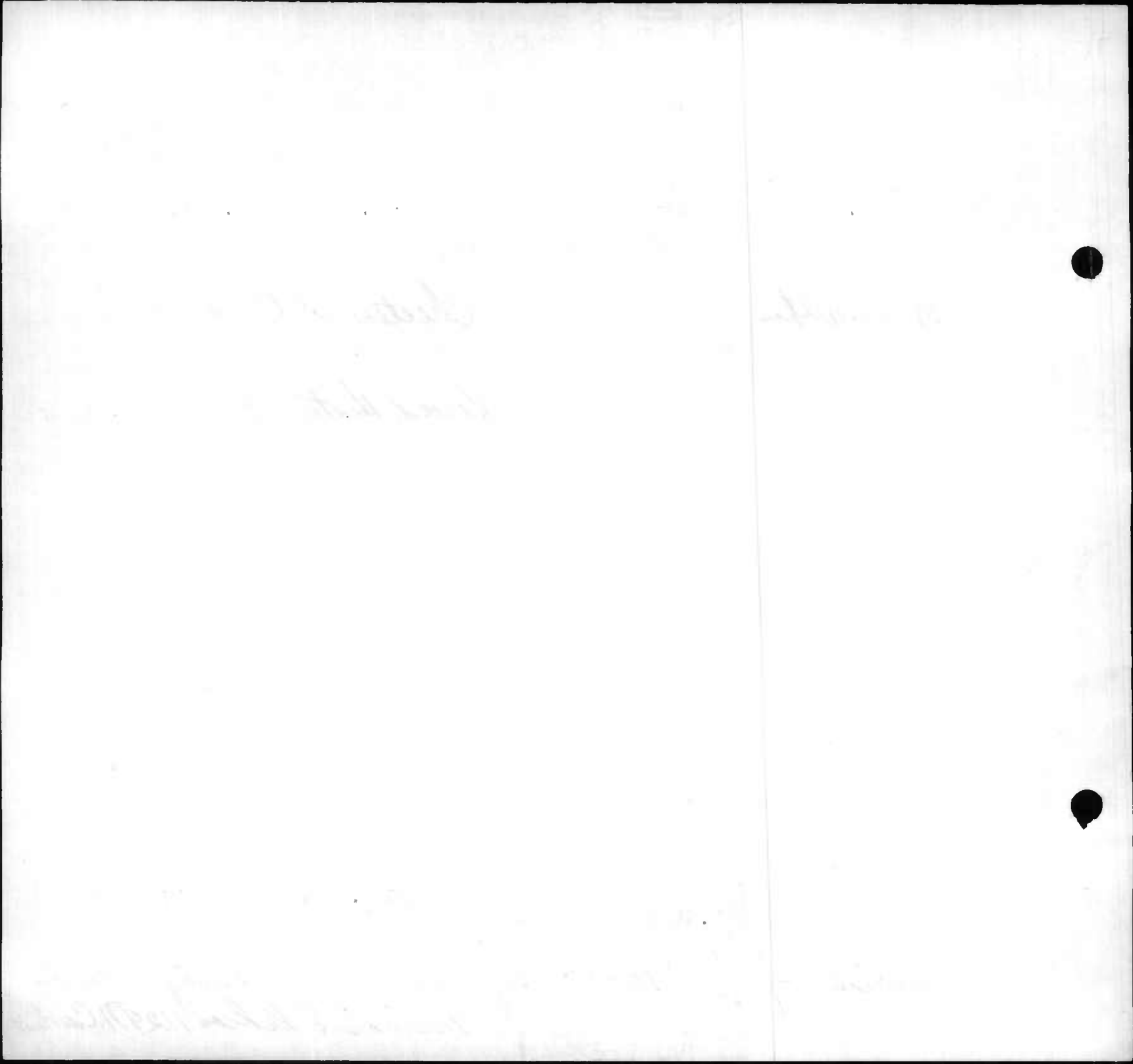
| BIRTH NO. 66 04201 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | # 629987 | | | |
|--|--|----------------------------|--|---|--|---|--|--|--|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | | Registered No. 66 04201 | | | |
| 1. NAME OF DECEASED
(Type or Print) VICTOR A. FENNELL | | | | 2. DATE AND HOUR OF DEATH
4/24/66 1:27 A.M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE md. B. COUNTY 25-32 | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
South Baltimore General Hospital | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Balto. md. | | | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
2452 Terra Firma Road | | | | | | | |
| 5. SEX
Male | | 6. RACE
Colored | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | | 8. DATE OF BIRTH
9/15/15 | | 9. AGE (In years last birthday)
50 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Postal Employee | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
John Fennell | | | | 14. MOTHER'S MAIDEN NAME
Jessie Boone | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes World War 2 | | | | 16. SOCIAL SECURITY NO.
1-0 | | 17. INFORMANT
Mildred Fennell | | | | ADDRESS
2452 Terra Firma Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
IRREVERSIBLE SHOCK | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
MASSIVE G.E. BLEEDING | | | | DUE TO | | | | 8 HRS | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
STRESS ULCER | | | | DUE TO | | | | 2 DAYS | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/9 19 66 to 4/24 19 66 , that (I) (we) last saw the deceased alive on 4/24 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
James F. McCarter | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/24/66 | |
| 23C. PHYSICIAN'S NAME (Type)
JAMES F. MCCARTER | | | | | | 23D. ADDRESS
SOUTH BALTIMORE GENERAL HOSPITAL 1213 LIGHT STREET | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
4/1/66 | | 24C. NAME OF CEMETERY or CREMATORY
Bald. National Cem. | | | | 24D. LOCATION (City, town, or county) (State)
5501 Fredrick Ave. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | | | 25B. NAME OF REGISTRAR
Paul E. Jenkins | | | | 25C. FUNERAL DIRECTOR
John T. Elickson | | | |
| | | | | | | | | ADDRESS
1129 N. Calver St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

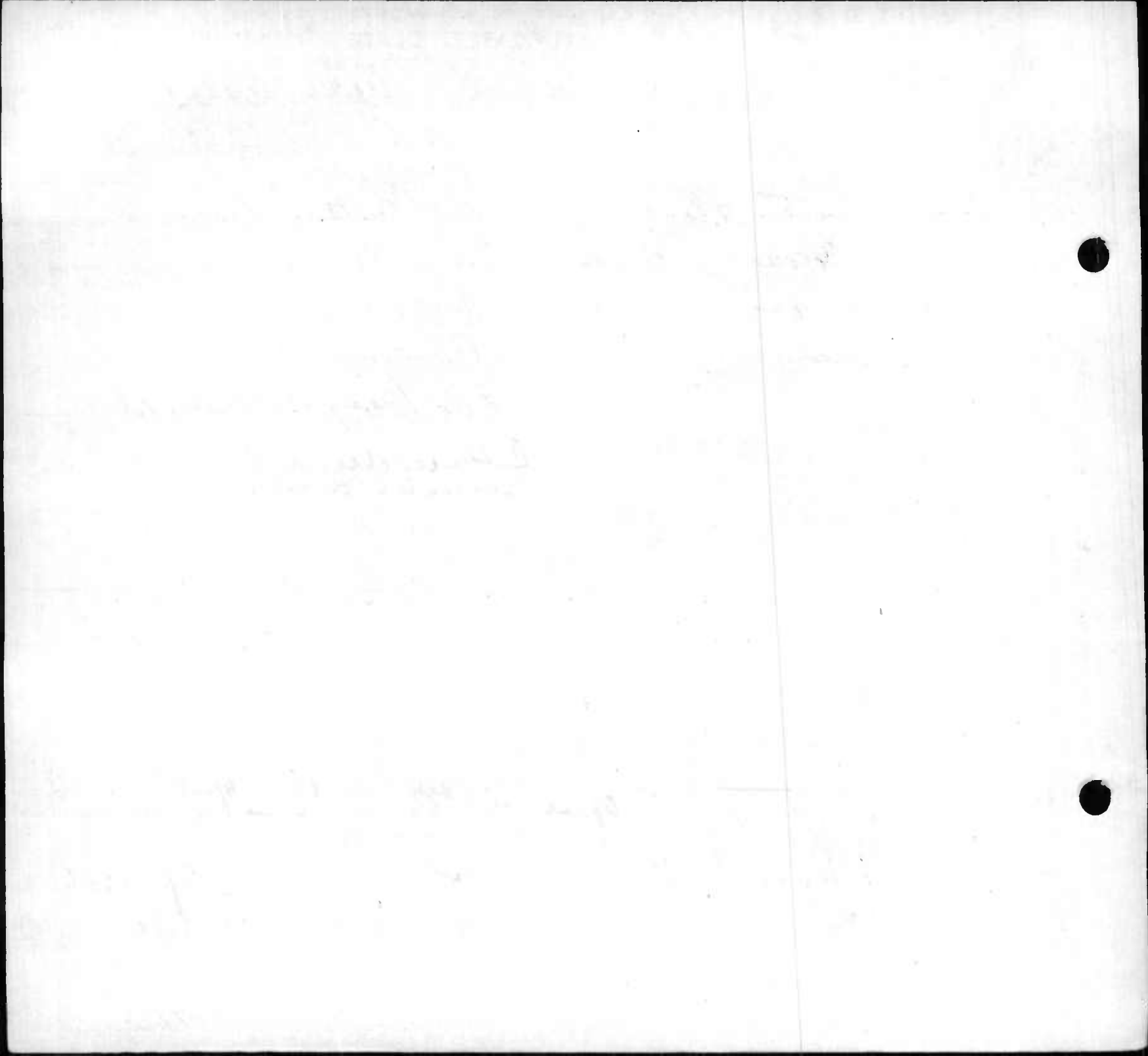
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|-------------------------|---|-----------------------------------|--|---|
| BIRTH NO.
66 04202 | | CERTIFICATE OF DEATH | | 66 04202 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>MARY HINTON</u> | | | |
| 2. DATE AND HOUR OF DEATH
<u>4/23/66</u> <u>11:30 P</u> M. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>BALTIMORE</u>
B. COUNTY <u>8-03</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>MARYLAND</u>
D. STREET ADDRESS (If rural, give location)
<u>1535 N. MILTON AVE . 21213</u> | | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>NEGRO</u> | 7. MARRIED, NEVER MARRIED
<u>WIDOWED</u> | 8. DATE OF BIRTH
<u>3/2/14</u> | 9. AGE (In years last birthday)
<u>52</u> | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Chester S. Carolina</u> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
<u>ALEXANDER YOUNG</u> | | 14. MOTHER'S MAIDEN NAME
<u>JANIE ?</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Harold Hinton 1902 Jefferson St</u> | |
| 18. <u>330X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>CAUSE OF DEATH</u>
(A) <u>SUBARACHNOID HEMORRHAGE 30 DAYS</u>
(B) <u>INTERVAL BETWEEN ONSET AND DEATH</u>
(C) <u>ANTECEDENT CAUSES</u>
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>T.B.P.</u> | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natally medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/20</u> 19 <u>66</u> to <u>4/23</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/23</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Ashley T. Haase</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Physician <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>4/23/66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>ASHLEY T. HAASE</u> | | 23D. ADDRESS
<u>601 N. BROADWAY 21205</u>
<u>THE JOHNS HOPKINS HOSPITAL</u> | | M.D. <u>JOHNS HOPKINS</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/28/66</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Mt Calvary Cem</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>A.A. County Md</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 25 1966</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Barber</u> | | 25C. FUNERAL DIRECTOR
<u>Milton E. E. Lisker</u> | | ADDRESS
<u>1129 N. Carroll</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66-04203 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66-04203 | |
|---|------------------------|--|--------------------------------------|---|----------------------------|--|-----------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Mary Wells</i> | | | | 2. DATE AND HOUR OF DEATH <i>April 22, 1966</i> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE <i>md.</i> B. COUNTY <i>11-04</i> | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | D. STREET ADDRESS (If rural, give location) | | | |
| <i>1321 Eutaw Place</i> | | | | <i>Baltimore</i> | | | |
| <i>1321 Eutaw Place</i> | | | | <i>1321 Eutaw Place</i> | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>Colored</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i> | 8. DATE OF BIRTH <i>Nov. 6, 1888</i> | 9. AGE (In years last birthday) <i>77</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Richmond Va.</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>W. A. Bridges</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Caroline Steven's</i> | | | |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Edna Bailey 1321 Eutaw Place</i> | |
| 18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) <i>arteriosclerotic heart disease</i> 10 months | | | |
| (B) DUE TO | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Feb 16</i> 19 <i>65</i> to <i>April 16</i> 19 <i>66</i> that (I) (we) last saw the deceased alive on <i>April 16</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Royton B. Scott</i> M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>April 23, 66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>ROUSTON B. SCOTT</i> | | | | 23D. ADDRESS <i>1801 W. Baltimore St. Baltimore 23 Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| <i>Burial</i> | | <i>April 24/66</i> | | <i>Arbutus Mem. Park</i> | | <i>Arbutus md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>APR 25 1966</i> | | 25B. NAME OF REGISTRAR <i>R. E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>Millon E. Elickson</i> | | ADDRESS <i>1129 N. Carroll St</i> | |

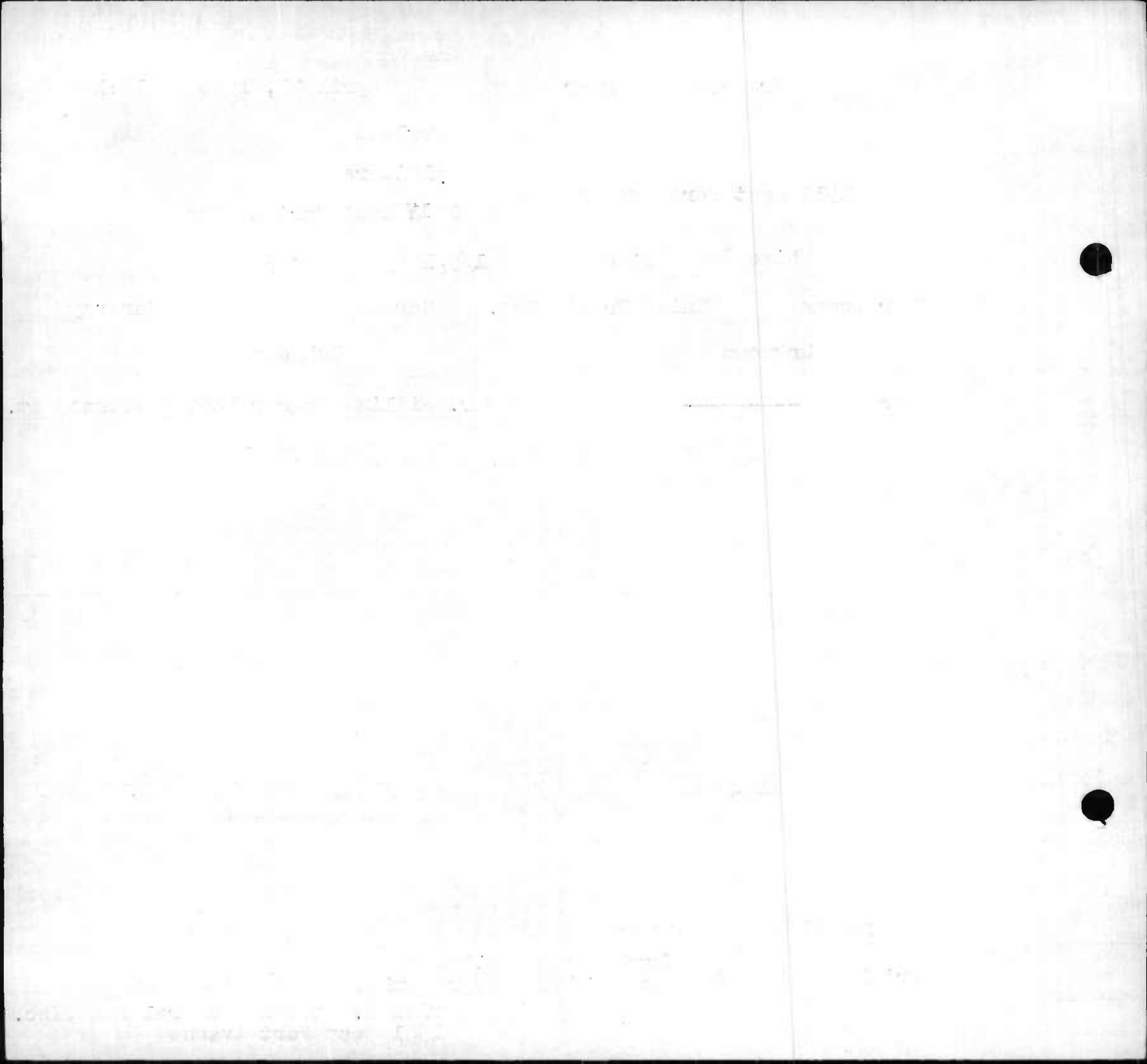


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

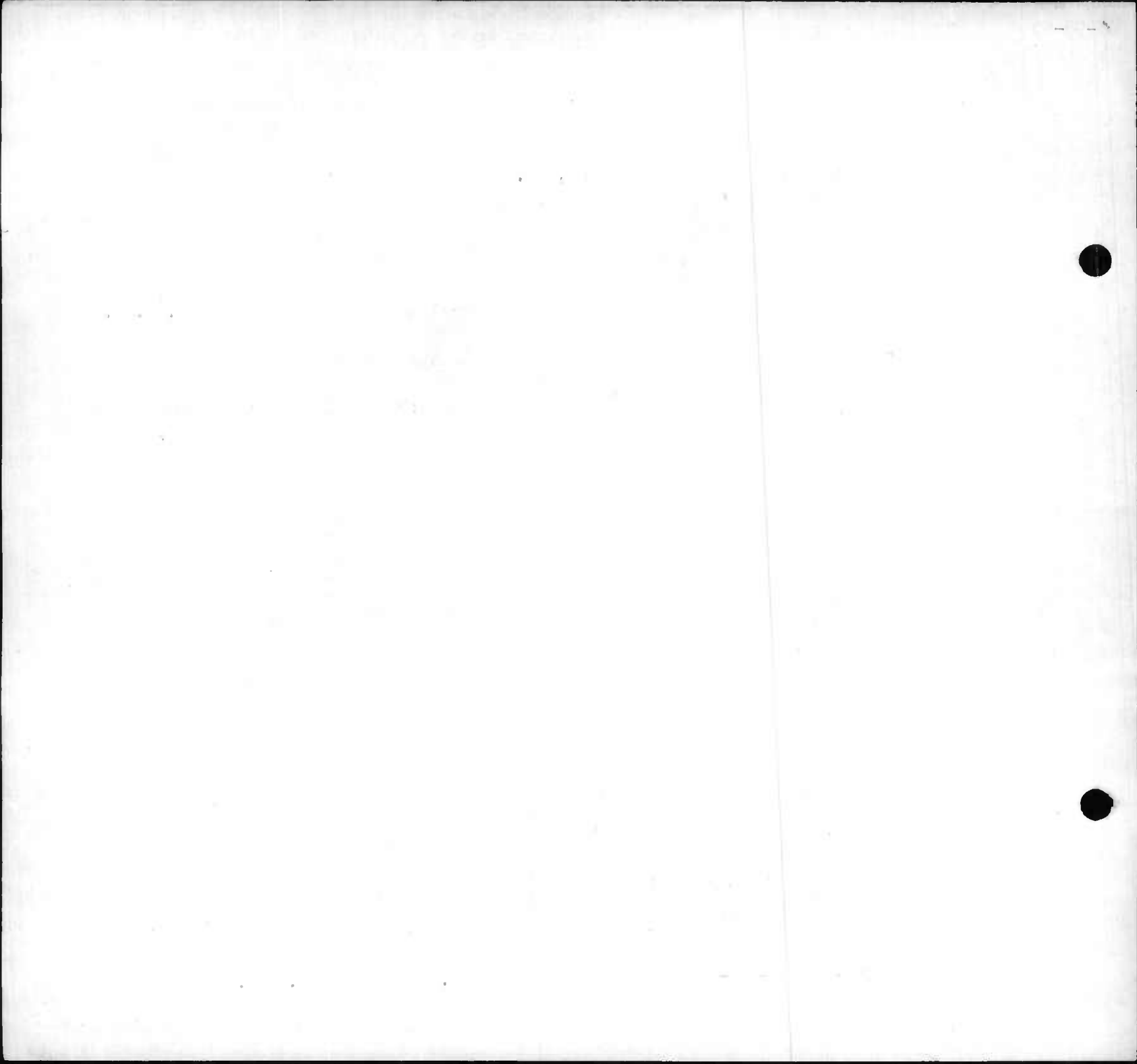
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 04204 | |
|--|-------------------------|---|-------------------------------------|---|---|---|---------------------------------|
| BIRTH NO. 66 04204 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Frances Wagner | | 2. DATE AND HOUR OF DEATH
April 21, 1966 11:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1517 East Fort Avenue | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 2401 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
1517 East Fort Avenue | | | |
| 5. SEX
F | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
1/9/1883 | 9. AGE (In years last birthday)
83 | II Under 1 Yr.
Months: Days: Hours: Min. | | II Under 24 Hrs.
Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Char woman | | 10B. KIND OF BUSINESS OR INDUSTRY
Union Trust Bldg. | | 11. BIRTHPLACE (State or foreign country)
Germany | | 12. CITIZEN OF WHAT COUNTRY?
Germany | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-22-462 | | 17. INFORMANT
Mr. William Wagner 1465 Stevens St. | | | |
| 18. 4-22-1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Conjunctive Heart Failure
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) DUE TO
Conjunctive Heart Failure
(B) DUE TO
Arteriosclerotic Cardiovascular Disease
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1965 19 to April 5 19 66 , that (I) (we) last saw the deceased alive on April 5 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Ricardo Lozada | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/22/66 | |
| 23C. PHYSICIAN'S NAME (Type)
RICARDO LOZADA | | | | 23D. ADDRESS
M.D. 1228 S. Charles A. Bldg. 3014 d. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/25/66 | | 24C. NAME OF CEMETERY
First German United Evangelical Congregation | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|-----------------------------|---|--|
| 45-93-89
13-6201 | | BALTIMORE CITY HEALTH DEPARTMENT | | 66 04205 | |
| BIRTH NO. 66 04205 | | CERTIFICATE OF DEATH | | Registered No. 66 04205 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) JAMES BROOKS | | 2. DATE AND HOUR OF DEATH
4/22/66 5:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
4940 Eastern Avenue Baltimore, Md.
BALTIMORE CITY HOSPITALS | | D. STREET ADDRESS (If rural, give location)
572 PRESSMAN ST | | 21217 | |
| 5. SEX
MALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
SEPARATED | 8. DATE OF BIRTH
5/18/07 | 9. AGE (In years last birthday)
58 | If Under 1 Yr. (If Under 24 Hrs. Min.) |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
John | | 14. MOTHER'S MAIDEN NAME
Lottie | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
RECORDS: BCH 4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
163X I
CAUSE OF DEATH
CARCINOMA OF THE LUNG
INTERVAL BETWEEN ONSET AND DEATH
2 MONTHS | | (A) DUE TO | | (B) DUE TO | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from FEBRUARY 16 1966 to APRIL 22 1966, that (I) (we) last saw the deceased alive on APRIL 22 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
James T. Sparks | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/22/66 | |
| 23C. PHYSICIAN'S NAME (Type)
JAMES T. SPARKS | | 23D. ADDRESS
BALTIMORE CITY HOSPITALS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-26-66 | | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | 25B. NAME OF REGISTRAR
Robert E. Sparks | |
| 25C. FUNERAL DIRECTOR
George Nelson | | ADDRESS
1348 Calhoun St. | | | |



L-200

66 04206

BALTIMORE CITY HEALTH DEPARTMENT

66 04206

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY HARCUM Lucy

2. DATE AND HOUR PRONOUNCED DEAD

April 22, 1966 10:35 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTIONIF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION

1023 N. Carrollton Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1023 N. Carrollton Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

11-28-07

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

John Harcum

14. MOTHER'S MAIDEN NAME

Lura Yerby

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

216-01-6189

17. INFORMANT

ADDRESS

Ella Reeder 1208 Eutaw Place

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH422.1 + 150X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO diseaseANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Carcinoma of esophagus

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-22-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4-26-66

23C. NAME of CEMETERY or CREMATORY

Balto. Nat'l Cem.

23D. LOCATION

(City, town, or county)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 25 1966

24B. NAME OF REGISTRAR

Robert E. [Signature]

24C. FUNERAL DIRECTOR

Gerry Libon 1348 Calhoun St.

ADDRESS

— 65 —

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 66 04207 | |
|--|-----------|--|--------------------------|--|-----------------------------|--|------------------------------|
| BIRTH NO. 66 04207 | | M.E. CASE NO. 66 04207 | | NAME OF DECEASED (Type or Print) MARY GOODEN | | DATE AND HOUR OF DEATH 4/23/66 12:05 A.M. | |
| PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME + HOSPITAL | | | | A. STATE MARYLAND B. COUNTY 13-03 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 2627 FRANCIS STREET 21217 | | | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE SEPARATED | 8. DATE OF BIRTH 3/13/22 | 9. AGE (In years last birthday) 44 | 10. Under 1 Yr. Months Days | | 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME CHARLES BLACKWELL | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT CHART | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | CEREBRAL HEMIPARALYSIS | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | HYPERTENSIVE CARDIO- | | | |
| | | | | VASCULAR DISEASE | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/22 1966 to 4/23 1966, that (I) (we) last saw the deceased alive on 4/23 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE MARIANO A. TOLENTINO M.D. | | | | 23B. DATE SIGNED 4/23/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) MARIANO A. TOLENTINO M.D. | | | | 23D. ADDRESS CHURCH HOME + HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4-27-66 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk. | | 24D. LOCATION (City, town, or county) Balto. (State) Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 25 1966 | | 25B. NAME OF REGISTRAR Robert E. Carby M.D. | | 25C. FUNERAL DIRECTOR George Gibson | | ADDRESS 1348 Calhoun St. | |

RECEIVED BY THE DIRECTOR

1-520 66 04208 BALTIMORE CITY HEALTH DEPARTMENT 66 04208

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____ M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) **MAGGIE JONES** 2. DATE AND HOUR PRONOUNCED DEAD **April 21, 1966 7:20 A.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD **1224 W. Stricker Street** 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE **Maryland** B. COUNTY _____
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **1224 N. Stricker Street**

5. SEX **Female** 6. RACE **Negro** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) _____ 8. DATE OF BIRTH **1-9-07** 9. AGE (In years last birthday) **59** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ 10B. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) **Va.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Daniel Layton** 14. MOTHER'S MAIDEN NAME _____

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT **Walter Jones** ADDRESS **1224 Stricker St.**

18. **443X** I **CAUSE OF DEATH** INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) **Hypertensive Cardiovascular Disease.**
(A) DUE TO _____
ANTECEDENT CAUSES (B) DUE TO _____
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) _____
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____

19A. DATE OF OPERATION _____ 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) **No** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. _____ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.) _____ 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR? _____

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Charles S. Petty, M.D.** CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) **Charles S. Petty, M.D.** M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED **4/21/66**

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **4-25-66** 23C. NAME of CEMETERY or CREMATORY **Mt. Calvary Cem.** 23D. LOCATION (City, town, or county) (State) **Balto., Md.**

24A. DATE REC'D BY HEALTH DEPT. **APR 25 1966** 24B. NAME OF REGISTRAR **Robert E. ...** 24C. FUNERAL DIRECTOR **George Nelson** ADDRESS **1348 Calhoun St.**

VALLEY FORCE

TO CONTAIN

1-1-10

Valley Force 1934

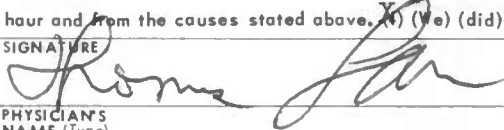
1-1-10

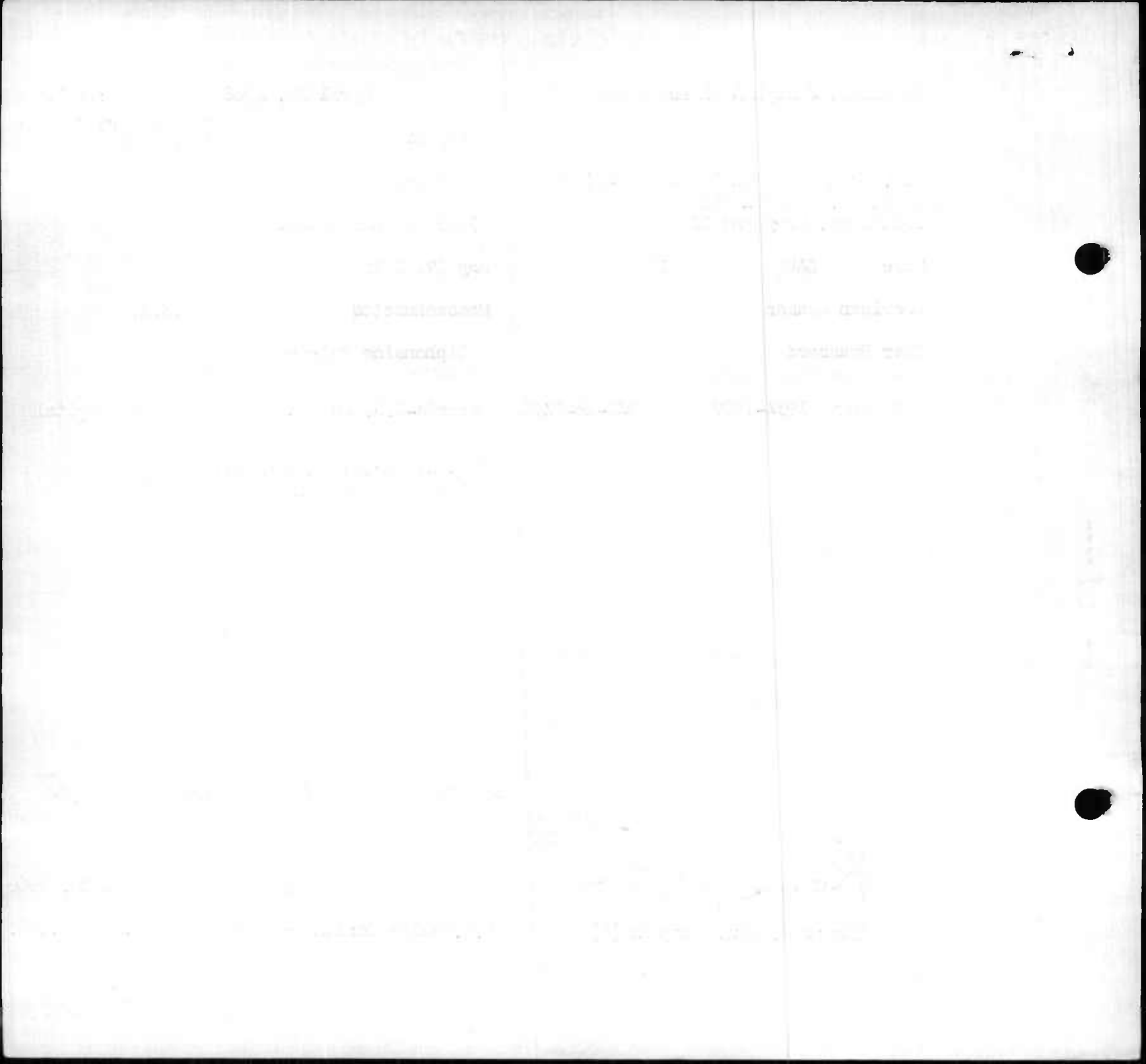
Valley Force 1934

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04209 | |
|---|-----------------------|--|---|--|---|
| BIRTH NO.
66 04209 | | M.E. CASE NO. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print)
BRASSARD, Joseph Alphonso Romero | | | 2. DATE AND HOUR OF DEATH
April 19, 1966 8:15 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
U.S. Public Health Service Hospital
31 st St. & Wyman Park Drive
Baltimore, Maryland 21211 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY 27-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
3025 Orlando Avenue | | |
| 5. SEX
Male | 6. RACE
CAU | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WID | 8. DATE OF BIRTH
May 17, 1915 | 9. AGE (in years last birthday)
50 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
American Seaman | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Massachusetts |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 13. FATHER'S NAME
Omer Brassard | | |
| 14. MOTHER'S MAIDEN NAME
Olphonsine Poirer | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
U.S. Army 1934-1937 | | |
| 16. SOCIAL SECURITY NO.
042-16-3452 | | | 17. INFORMANT ADDRESS
Records-U.S. Public Health Service Hospital | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
491X I
Bronchopneumonia, confluent, Days
with abscess formation
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION
6 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 19, 1966 to April 19, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 19, 1966 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | |
| 23A. SIGNATURE

M.D. Thomas J. Lau, Surgeon (R) | | | | 23B. DATE SIGNED
April 20, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
Thomas J. Lau, Surgeon (R) | | | | 23D. ADDRESS
M.D. U.S. Public Health Service Hospital, Balto., Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/23/66 | | 24C. NAME OF CEMETERY or CREMATORY
NEW CATHEDRAL | |
| 24D. LOCATION (City, town, or county) (State)
BALTO. MD. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Sisk | | 25C. FUNERAL DIRECTOR
Paul E. Chevone
ADDRESS
3617 Chestnut Ave. | | | |

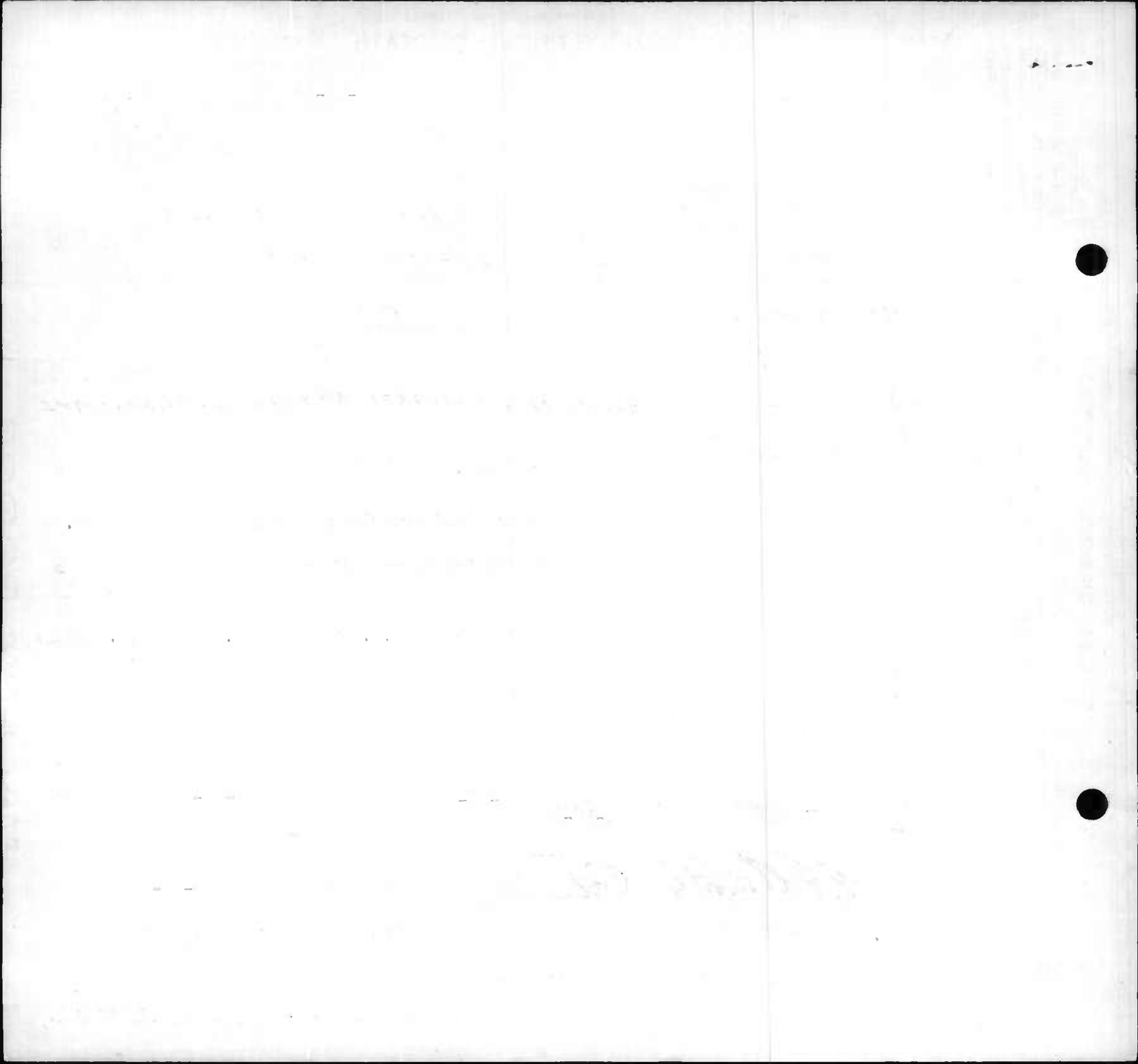


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04210 | |
|--|----------------------|--|---------------------------------|---|---|
| BIRTH NO. 66 04210 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) BESSIE KARNOLD | | 2. DATE AND HOUR OF DEATH
4-18-66 11:55 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
BOLTON HILL NURSING HOME | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY 27-18
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.
D. STREET ADDRESS (If rural, give location) 5301 LUTHBERT AVE | | | |
| 5. SEX F | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 5/23/76 | 9. AGE (In years lost birthday) 87 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME ? | | 14. MOTHER'S MAIDEN NAME ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 219-30-9926 | | 17. INFORMANT ADDRESS MARGARET RAY 5301 LUTHBERT AVE | |
| 18. 443X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTecedent CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Gangrene, toes left foot
DUE TO
(B) generalized arteriosclerosis
DUE TO
(C) congestive heart failure | | INTERVAL BETWEEN ONSET AND DEATH
several weeks
several yrs.
several weeks | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Hypertensive C.V. disease sec. to B sev. months | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-17-66 to 4-18-66 that (we) last saw the deceased alive on 4-18-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE E. Ellsworth Cook M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED 4-20-66 | |
| 23C. PHYSICIAN'S NAME (Type) E. ELLSWORTH COOK | | 23D. ADDRESS 2431 MARYLAND AVE BALTIMORE 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 4/22/66 | | 24C. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL | |
| 24D. LOCATION (City, town, or county) BALTO. | | 24E. (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 25 1966 | | 25B. NAME OF REGISTRAR P. E. ELLSWORTH | | 25C. FUNERAL DIRECTOR ADDRESS Paul E. Ellsworth 3617 Jackson Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 66 04211 | |
|--|------------------|---|------------------------------------|--|--|--|--|
| BIRTH NO. 66 04211 | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) Anna C. Huster | | | | 2. DATE AND HOUR OF DEATH
April 22, 1966 3:20 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

454 S. Furrow St. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Balto.

D. STREET ADDRESS (If rural, give location)
454 S. Furrow St. | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
Sept. 19, 1879 | 9. AGE (In years last birthday)
86 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Wife | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Wife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Balto. Md. | | |
| 13. FATHER'S NAME
John W. Kratz | | | | 14. MOTHER'S MAIDEN NAME
Eva E. Kramer | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 16. SOCIAL SECURITY NO.
219-12-9816a | | 17. INFORMANT
Balto. Md. 21223
Mrs. Verna E. Hofmann 454 S. Furrow St. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
Respiratory Failure
Hemiplegia
Hypertension & Arteriosclerosis
Coronary Artery Disease | | | |
| 19. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from January 1966 to April 22, 1966, that (I) (we) last saw the deceased alive on April 22, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
S. Borofsky | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/23/66 | |
| 23C. PHYSICIAN'S NAME (Type)
S. BOROFSKY | | | | 23D. ADDRESS
601 N. Howard St. Balto. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
April 25, 1966 | | 24C. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem. | | 24D. LOCATION (City, town, or county) (State)
Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1966 | | 25B. NAME OF REGISTRAR
G. Truman Schwab | | 25C. FUNERAL DIRECTOR
G. Truman Schwab 3512 Frederick Ave. Balto. Md. | | | |

Department of Justice
Washington, D.C.
April 10, 1914

April 10, 1914

J. M. [unclear]
200 [unclear]

✓
1000 [unclear]

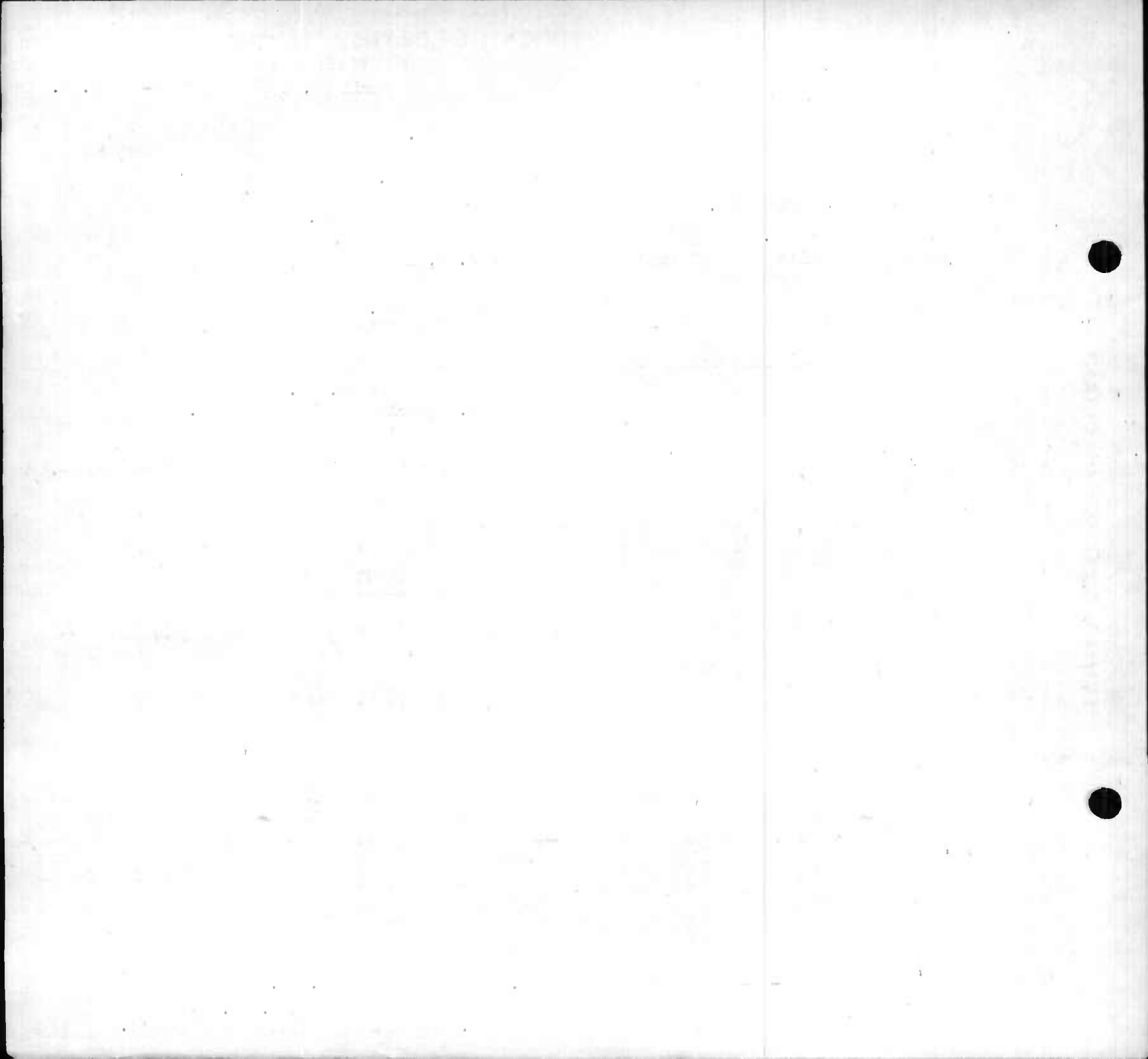
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 66 04212 | |
|---|-------------------------|---|---|---|--|
| CERTIFICATE OF DEATH | | | | Registered No. | |
| BIRTH NO.
66 04212 | | 2. DATE AND HOUR OF DEATH
April 22, 1966 8-45 A. M. M. | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Anna Metz</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

327 Yale Ave. | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Md.</u>
B. COUNTY <u>20-88</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Balto.</u>
D. STREET ADDRESS (If rural, give location)
<u>327 Yale Ave.</u> | | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Widowed</u> | 8. DATE OF BIRTH
<u>Jan. 5, 1879</u> | 9. AGE (In years last birthday)
<u>87</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>House Wife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Allegany Co.</u> | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME
<u>William Williamson</u> | | 14. MOTHER'S MAIDEN NAME
<u>Ellen Kirkland</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Mr. Francis Metz 327 Yale Ave.</u> | | ADDRESS
<u>Balto. Md. 21229</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Hypertensive Cerebral Disease</u> | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
<u>Many Years</u> | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>Acute Respiratory Disease Several days</u> | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from <u>Jan. 1964</u> to <u>4.22 1966</u> , that (I) (we) last saw the deceased alive on <u>4.21. 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Abraham Goldman</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>4.23.66</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4-25-1966</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Meadowridge Cem.</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Balto. Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 25 1966</u> | | | |
| 25B. NAME OF REGISTRAR
<u>G. Truman Schwab</u> | | 25C. FUNERAL DIRECTOR
<u>Balto. Md. 21229</u> | | | |
| 25D. ADDRESS
<u>3512 Frederick Ave.</u> | | | | | |



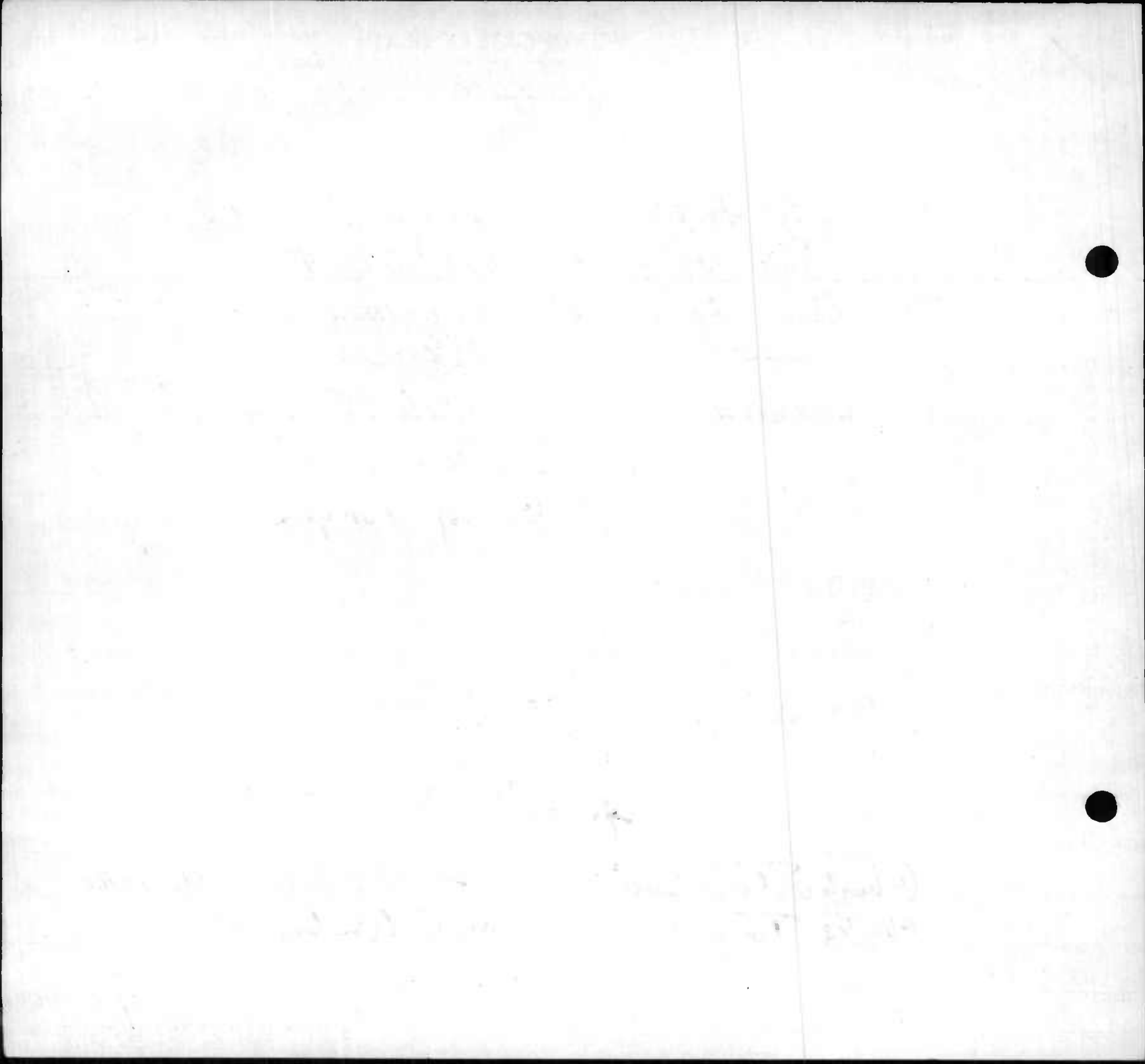
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|-------------------------------------|---|--|
| BIRTH NO. 66 04213 | | CERTIFICATE OF DEATH | | Registered No. 66 04213 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Emmett N. Russell</i> | | 2. DATE AND HOUR OF DEATH
<i>4/22/66</i> <i>9:30 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <i>md.</i> B. COUNTY <i>18-03</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>University Hospital</i> | | D. STREET ADDRESS (If rural, give location)
<i>863 W. Lombard St.</i> | | | |
| 5. SEX
<i>male</i> | 6. RACE
<i>white</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Divorced</i> | 8. DATE OF BIRTH
<i>4/2/1917</i> | 9. AGE (In years last birthday)
<i>49</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Electrician</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Local 24 Union</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Hagerstown Md.</i> | |
| 13. FATHER'S NAME
<i>John Russell</i> | | 14. MOTHER'S MAIDEN NAME
<i>Effie ?</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>yes World War II</i> | | 16. SOCIAL SECURITY NO.
<i>7 -</i> | | 17. INFORMANT
<i>Mr. Glenn E. Russell</i> ADDRESS <i>1805 E. Burnside</i> | |
| 18. <i>161X I</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) <i>Sen. Carcinomatosis</i> | | | |
| | | (B) <i>Ca. of Larynx</i> | | <i>2 years</i> | |
| | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 12</i> 1964 to <i>Apr 21</i> 1966, that (I) (we) last saw the deceased alive on <i>Apr 21</i> 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Charles Townesello</i> | | | | 23B. DATE SIGNED
<i>Apr. 22/66</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Charles Townesello</i> | | 23D. ADDRESS
<i>900 W. Lombard St.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>4/25/66</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Baltimore National Cem.</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>5301 Redbrick Ave</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>APR 25 1966</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Smith</i> | |
| 25C. FUNERAL DIRECTOR
<i>John J. Cowanston Inc.</i> | | 25D. ADDRESS
<i>23, Md.</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04214 | |
|---|---------|--|------------------|--|-----------------------------|
| BIRTH NO.
M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Edwin R. Long | | April 20, 1966 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| South Baltimore General Hospital | | Maryland - 25-33 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore 30 (Westport) | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | *2333 Annapolis Road | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| Male | White | Married | Jan. 9, 1898 | 68 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Barber (ret.) | | Self-Employed | | Shelton, Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Sidney C. Long | | Estella M. Adams | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Yes | | W.W.II | | Mrs. Elizabeth A. Long (wife) Same As #2 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | 24 L. | |
| ANTECEDENT CAUSES | | (B) DUE TO | | Year | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | Sec | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1962 to 1966, that (I) (we) last saw the deceased alive on 4/18/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| [Signature] | | | | 4/23/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| A. I. H. | | | | 206 S. Fulton | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | April 25, 1966 | | Glen Haven Mem. Park | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Glen Burnie, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| APR 26 1966 | | Robert E. Taylor, M.D. | | R.V. Singleton | |
| | | | | Singleton Funeral Home | |
| | | | | Glen Burnie, Md. | |

1911

Quadrants etc. - 1/2

1/2

1/2

1/2

1/2

1/2

1/2

1/2

1/2

1/2

1/2

FUNERAL DIRECTOR: IMPORTANT


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

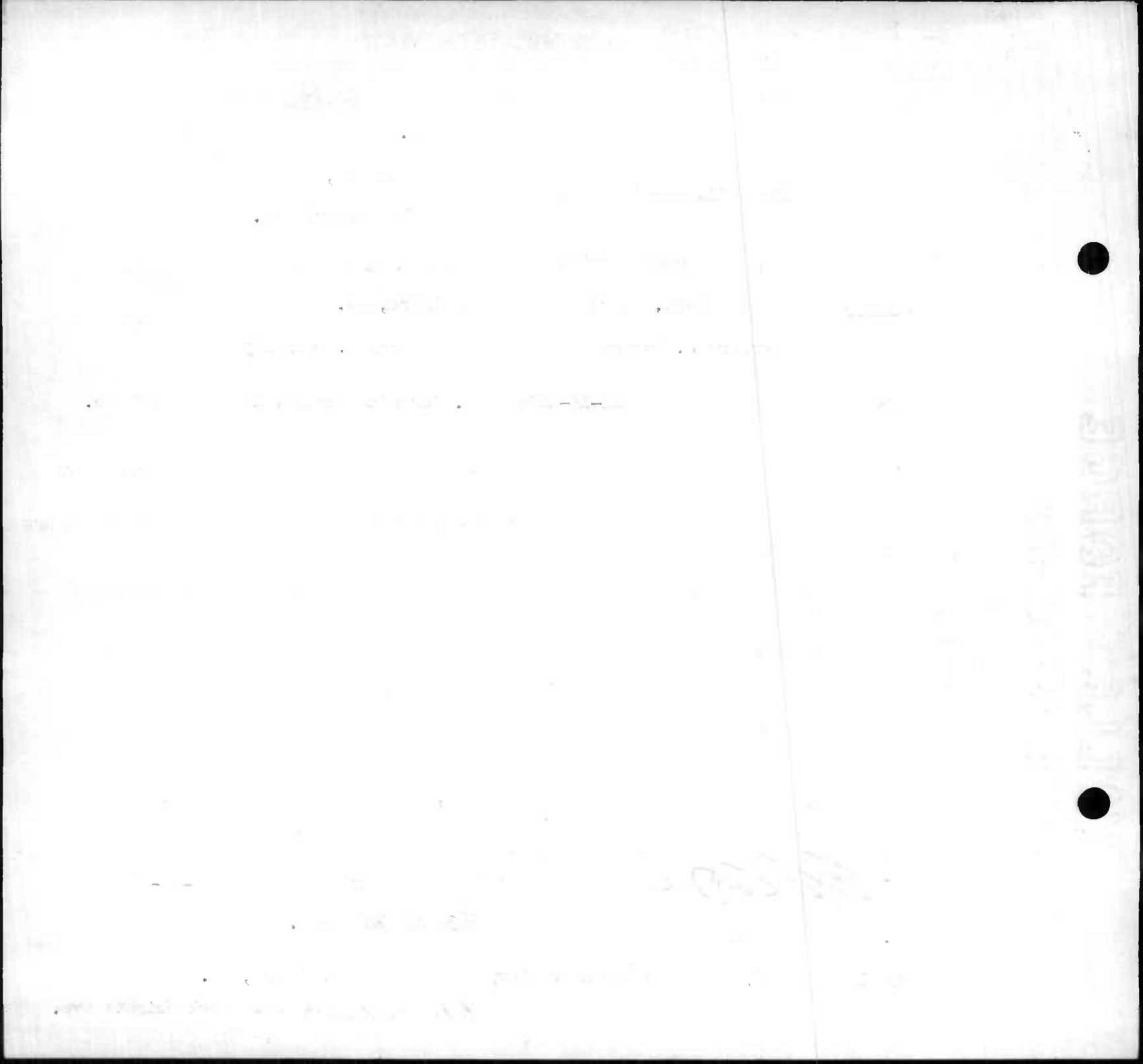
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>4215</u> | |
|--|---------------------|--|---|---|--|
| W-420 | | 66 04215 | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>LOMA GAY WELCH</u> | |
| 2. DATE AND HOUR OF DEATH
<u>22 April 1966 3:40 P.</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <u>Mo.</u> B. COUNTY <u>27-03</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>UNION MEMORIAL HOSPITAL</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | | | |
| (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location)
<u>2814 Alisa Ave. Alsea</u> | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>NEVER MARRIED</u> | 8. DATE OF BIRTH
<u>Nov. 4, 1907</u> | 9. AGE (In years last birthday)
<u>59</u> | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>? Clerical</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Soc. Security</u> | | 11. BIRTHPLACE (State or foreign country)
<u>VIRGINIA</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | | | | |
| 13. FATHER'S NAME
<u>William Welch</u> | | 14. MOTHER'S MAIDEN NAME
<u>Della Blevins</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>231-18-4169</u> | | 17. INFORMANT ADDRESS
<u>MR. LARRY WELCH - NEPHEW - SAME</u> | |
| 18. <u>443X I</u> | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) <u>CEREBRAL HEMORRHAGE</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>20 hrs.</u> | |
| ANTECEDENT CAUSES | | (B) <u>Hypertensive ARTERIOSCLEROTIC HEART DISEASE</u> | | <u>10 yrs.</u> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from <u>21 April 1966</u> to <u>22 April 1966</u> , that we (we) last saw the deceased alive on <u>22 April 1966</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. It (We) (did) did not view the body after death. | | | | | |
| 23A. SIGNATURE
<u>L. Evan Custer</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>22 April 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>DR. L. EVAN CUSTER</u> | | 23D. ADDRESS
M.D. <u>Eugenia R. Seitz 5209 York Rod Balto. Md. 21212</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/25/1966</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>St. Matthews Centery</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 26 1966</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Farley</u> | | 25C. FUNERAL DIRECTOR
<u>Eugenia R. Seitz 5209 York Rod Balto. Md. 21212</u> | |

100 . L . 101

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

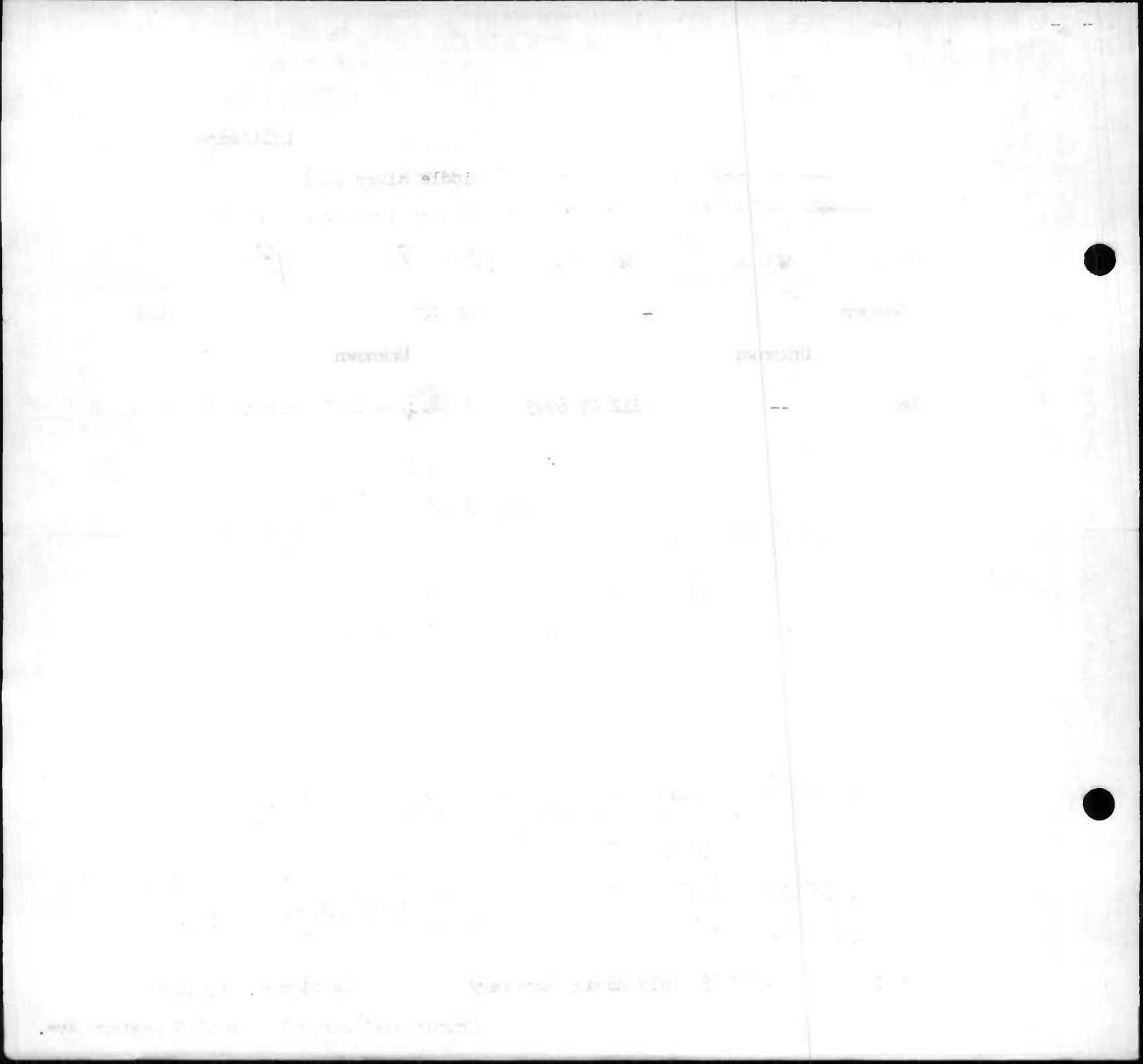
| | | | | | |
|---|---------------------|---|--|--|---|
| BIRTH NO. 66 04216 | | CERTIFICATE OF DEATH | | Registered No. 66 04216 | |
| M.E. CASE NO. Mary Hogarty | | 2. DATE AND HOUR OF DEATH
1/21/66 2 PM | | | |
| 1. NAME OF DECEASED (Type or Print)
Bolton Hill Nursing Home | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 15-13 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Bolton Hill Nursing Home | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore,
D. STREET ADDRESS (If rural, give location)
2815 Waldorf Ave. | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Never Married | 8. DATE OF BIRTH
April 1, 1890 | 9. AGE (In years last birthday)
76 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cashier | | 10B. KIND OF BUSINESS OR INDUSTRY
Dept. Store | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
Bernard J. Hogarty | | | |
| 14. MOTHER'S MAIDEN NAME
Mary C. Donnelly | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
212-18-2284 | | 17. INFORMANT ADDRESS
Mrs. Veronica Wunder, 2815 Waldorf Ave. | | | |
| 18. 331X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) Cerebro-vascular accident
DUE TO
(B) Cerebro-vascular arterio sclerosis
DUE TO
(C) Several Years
INTERVAL BETWEEN ONSET AND DEATH
Several Hours | | 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from March 9, 1966 to April 24, 1966 that (I) (we) last saw the deceased alive on April 23, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
 | | M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4-24-66 | |
| 23C. PHYSICIAN'S NAME (Type)
E. ELLSWORTH COOK | | 23D. ADDRESS
2481 MARYLAND AVE. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/28/66 | | 24C. NAME OF CEMETERY OR CREMATORY
Cathedral Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1966 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS
6. Vernon Somers 4611 Park Heights Ave. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

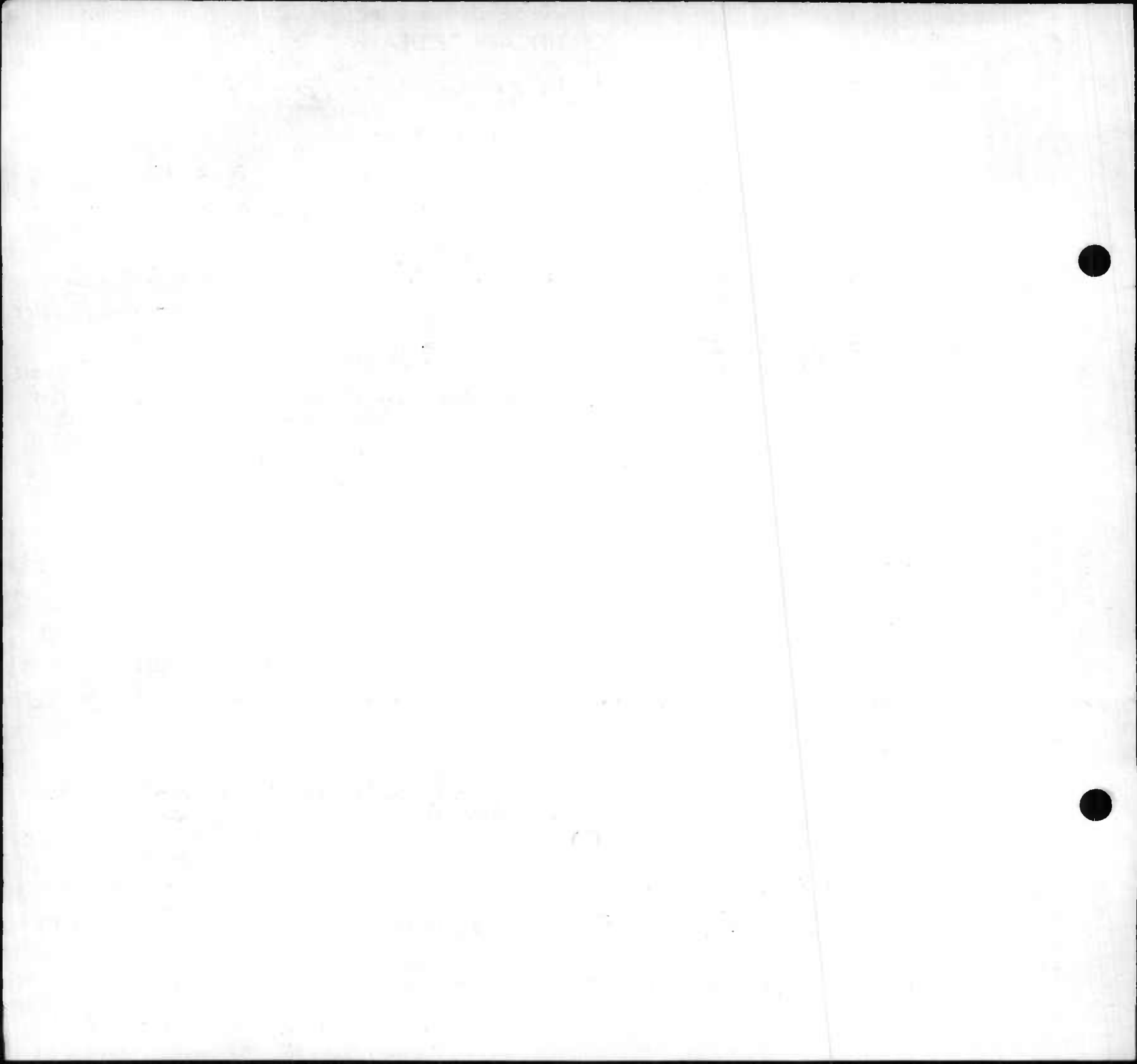
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04217 | |
|--|--|---|--|--|--|
| BIRTH NO. K-322 66 04217 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MARTIN T. KWIATKOWSKI | | | |
| 2. DATE AND HOUR OF DEATH 4-23-66 11:00 P.M. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MD. 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | |
| 8. DATE OF BIRTH 10-11-73 | | 9. AGE (In years, lost birthday) 92 | | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cooper | | 10B. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Germany | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -- | | 16. SOCIAL SECURITY NO. 212 07 6965 | | 17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224 | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH (A) DUE TO R/O CVA (B) DUE TO R/O MI (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 1 week | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pernicious Anemia | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? III in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-23-66 to 4-23-66, that (I) (we) last saw the deceased alive on 4-23-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Alex Silverman M.D. | | 23B. DATE SIGNED 4-23-66 | | | |
| 23C. PHYSICIAN'S NAME (Type) ALEX SILVERMAN | | 23D. ADDRESS 4940 Eastern Avenue 21224 90 BALTIMORE CITY HOSPITALS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4/27/66 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Bruzdinski Funeral Home 1407 Eastern Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

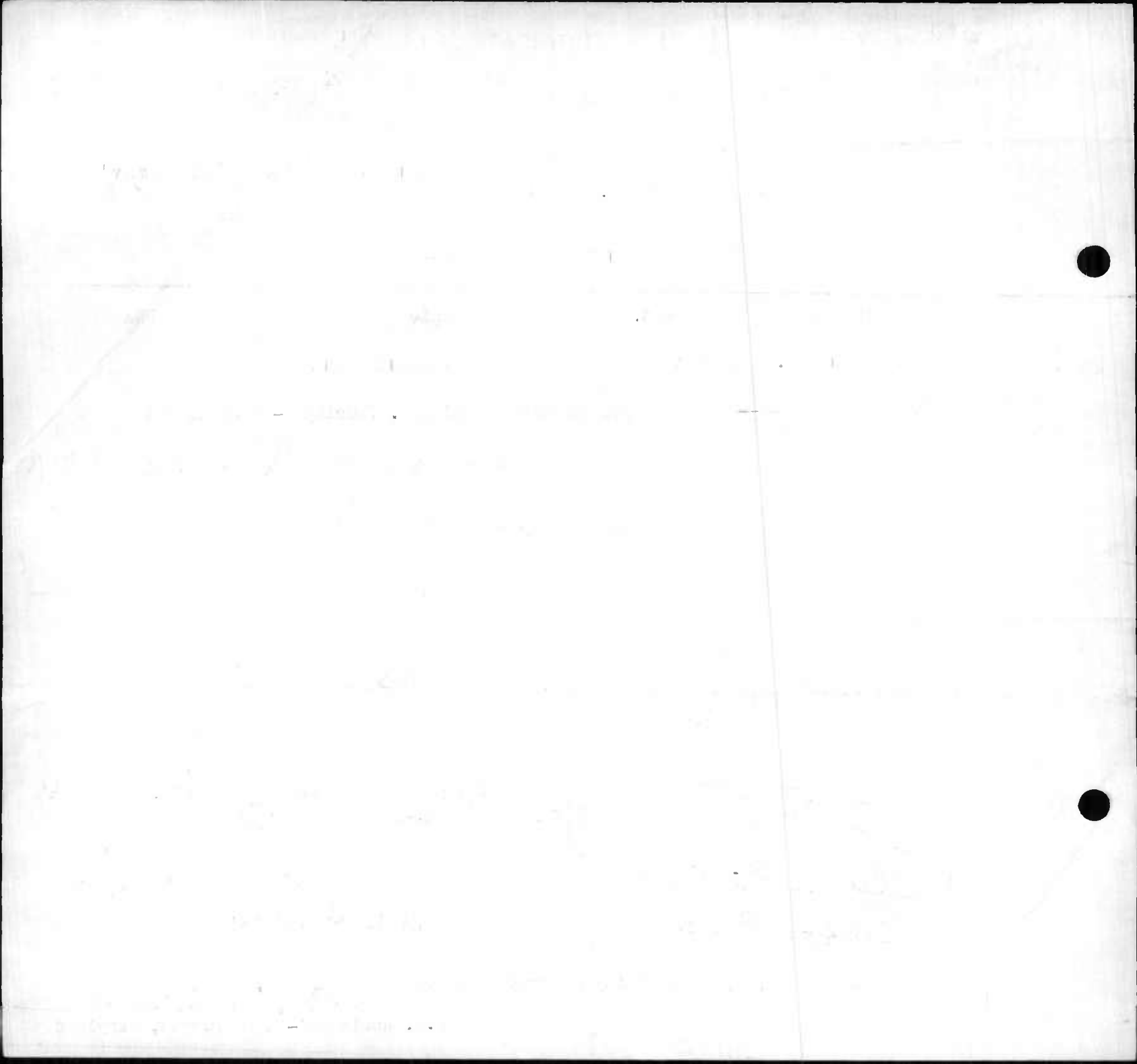
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04218 | |
|---|---------|--|------------------|--|-----------------------------|
| 66 04218 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED | |
| | | | | Fouche, Marcel Eugene | |
| 2. DATE AND HOUR OF DEATH | | 4/24/1966 10 A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Montebello State Hosp Baltimore | | Maryland 27-38 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore 212 12 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 5809 Halwyn Ave | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| M | W | M. | 6/30/1899 | 66 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| cook | | | | France | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Felix J. Fouche | | Maria J. Lamont | | US France | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| ? | | 215-10-4751 | | Mrs Mary Cummons 739 Cator Ave Baltimore | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) Squamous Cell Ca of Tongue | | 1 yr. | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/21/66 to 4/24/66, that (I) (we) last saw the deceased alive on 4/24/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Hea Rean LEW M.D. | | | | 4/24/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| HEA REAN LEW M.D. | | | | Montebello State Hosp. Baltimore | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 4/26/66 | | Holy Redeemer Cemetery Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| APR 26 1966 | | Robert E. Farley | | Eugenia K. Satz 5209 York Rd | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|-------------------------|--|------------------------------------|--|--|
| BIRTH NO.
66 04219 | | CERTIFICATE OF DEATH | | 66 04219 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) THURLBY, STANLEY. H. | | 2. DATE AND HOUR OF DEATH
4/23/66 3:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MARYLAND
B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
JOHNS HOPKINS HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
LEXINGTON PARK (ST. MARY'S COUNT | | | |
| | | D. STREET ADDRESS (If rural, give location)
303 S.W. SUWANE PLACE 68-00 | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
MARRIED | 8. DATE OF BIRTH
4-18-02 | 9. AGE (In years last birthday)
64 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY
Dept. Store | | 11. BIRTHPLACE (State or foreign country)
Ohio | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
BENJAMIN F. THURLBY | | | |
| 14. MOTHER'S MAIDEN NAME
JESSIE WHITE | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | |
| 16. SOCIAL SECURITY NO.
578 32 6686 | | 17. INFORMANT
Ellen W. Thurlby - same as #4 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)
330X I
SUB-ARACHNOID HEMORRHAGE 9 days
PROBABLE ANEURYSM | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/15 19 66 to 4/23 19 66 .
that (I) (we) last saw the deceased alive on 4/23 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Charles Burton | | | | 23B. DATE SIGNED
4/23/66 | |
| 23C. PHYSICIAN'S NAME (Type)
CHARLES BURTON | | 23D. ADDRESS
601 N. Broadway. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/26/66 | | 24C. NAME OF CEMETERY or CREMATORY
Trinity Memorial Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Waldorf, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1966 | | | |
| 25B. NAME OF REGISTRAR
P. B. Robinson | | 25C. FUNERAL DIRECTOR
P. B. Robinson & Leonardtown, Maryland | | | |

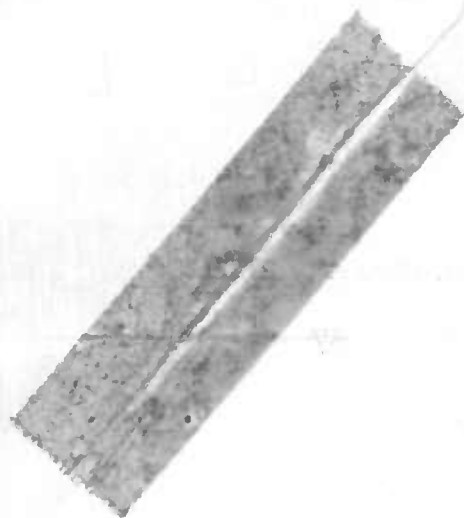


45-48-82
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66-04220 | |
|---|---------------|--|---|---|---|
| BIRTH NO. 620 66-04220 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) Walter B. Bowers (Blaszkowski) | |
| 2. DATE AND HOUR OF DEATH 4/23/66 1 A M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY Maryland | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location) 21 N. Bradford Street 21224 | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 11-7-98 | 9. AGE (In years last birthday) 67 | 10. Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen. Maintenance | | | 10B. KIND OF BUSINESS OR INDUSTRY Rigging | | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 13. FATHER'S NAME George Blaszkowski | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 212-14-0153 | | |
| 17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224 | | | ADDRESS | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) sepsis, probable (B) 1-sided pneumonia 24 hrs (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-6 1966 4/23 1966 that (I) (we) last saw the deceased alive on 4/23 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE James Sam Louie M.D. | | | | 23B. DATE SIGNED 4/23/66 | |
| 23C. PHYSICIAN'S NAME (Type) JAMES SAM LOUIE M.D. | | | | 23D. ADDRESS 4940 Eastern Avenue Baltimore City 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4/26/66 | | 24C. NAME OF CEMETERY or CREMATORY St. Stanislaus | |
| 24D. LOCATION Baltimore, Maryland | | 24E. NAME OF REGISTRAR M. F. SADOWSKI & SONS, 1808 EASTERN AVE | | 24F. FUNERAL DIRECTOR ADDRESS | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 26 1966 | | 25B. NAME OF REGISTRAR M. F. SADOWSKI & SONS, 1808 EASTERN AVE | | 25C. FUNERAL DIRECTOR ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---------|--|--|--|------------------|--|---|--|--|--|------------------------------|--|--|--|--|--|--|--|----------------------------------|--|--|--|
| 66 04221 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 04221 | | | | | | | | | | | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | | 1. NAME OF DECEASED
(Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | | | | | |
| | | | | | Thomas McCauley Sr. | | | | | 4-23-1966 8:45 A M. | | | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | | | | | | | A. STATE B. COUNTY | | | | | | | | | | | | | |
| (If not in hospital or institution, give street address or location) | | | | | | | | | | Md. | | | | | | | | | | | | | |
| 6605 Walther Avenue #6 | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | | | | | | | | | |
| | | | | | | | | | | Baltimore, Maryland | | | | | | | | | | | | | |
| D. STREET ADDRESS (If rural, give location) | | | | | | | | | | 6605 Walther Avenue #6 | | | | | | | | | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | | | | | | | | |
| Male | | White | | Married | | 7/23/1900 | | 65 | | | | | | | | | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | | |
| SALES MAN. | | | | PHARMACY. | | | | PHILADELPHIA PENNA. | | | | U.S.A. | | | | | | | | | | | |
| 13. FATHER'S NAME | | | | | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| THOMAS B MCCAULEY SR. | | | | | | | | | | ANNA DEISS | | | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | ADDRESS | | | | | | | | |
| No. | | | | | 164-10-2155 | | | | | MRS. MARY E. MCCAULEY | | | | | | | | | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | | | | | CAUSE OF DEATH | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | (A) Carcinoma of lung = metastasis | | | | | | | | | | 8 months | | | |
| ANTECEDENT CAUSES | | | | | | | | | | (B) DUE TO | | | | | | | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | (C) DUE TO | | | | | | | | | | | | | |
| II | | | | | | | | | | | | | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | | | | | |
| | | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 1966 to April 1966, that (I) (we) last saw the deceased alive on April 21 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | 23B. DATE SIGNED | | | | | | | | |
| Charles M. Kerr | | | | | | | | | | | | | | | April 25-66 | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | | | | | 23D. ADDRESS | | | | | | | | | | | | | |
| Charles M. Kerr M.D. | | | | | | | | | | 6801 Belair Rd. Balto G Md. | | | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | | 24B. DATE | | | | | 24C. NAME OF CEMETERY or CREMATORY | | | | | 24D. LOCATION (City, town, or county) (State) | | | | | | | | |
| BURIAL | | | | | 4/25/66 | | | | | PARKWOOD CEM. | | | | | PARKVILLE MD. | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | | 25B. NAME OF REGISTRAR | | | | | 25C. FUNERAL DIRECTOR | | | | | ADDRESS | | | | | | | | |
| APR 26 1966 | | | | | R. E. Johnson | | | | | Joseph Funeral Home | | | | | 7401 Belair Rd. | | | | | | | | |

James H. [unclear]

Apr 21 1880

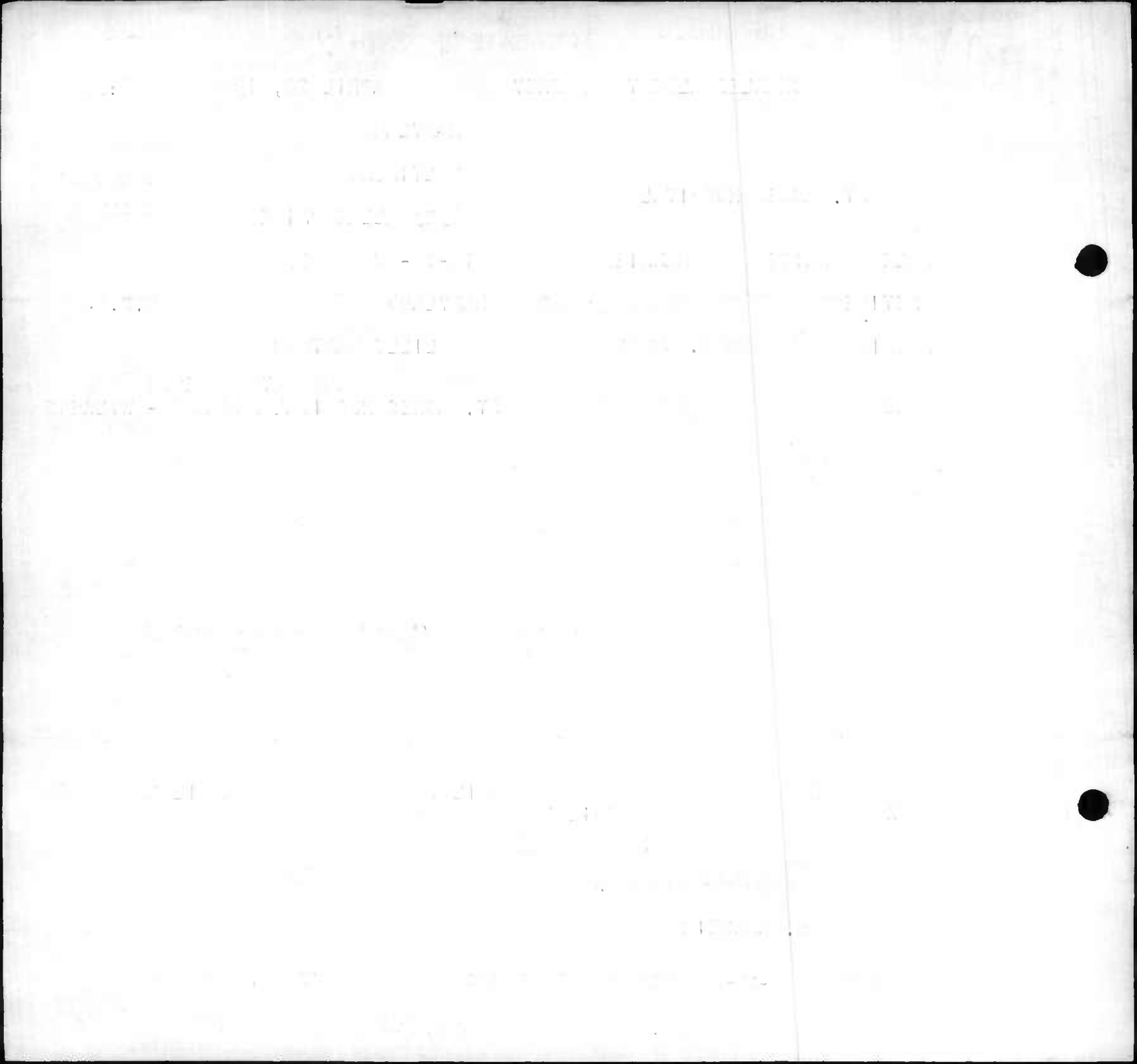
Chas. H. [unclear] 1880

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------|---|--|--|---|--|--|--|--|
| 66 04222 | | | | | Registered No. 66 04222 | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| | | | | CHARLES ALBERT WASKEY | | | APRIL 20, 1966 7:35 P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

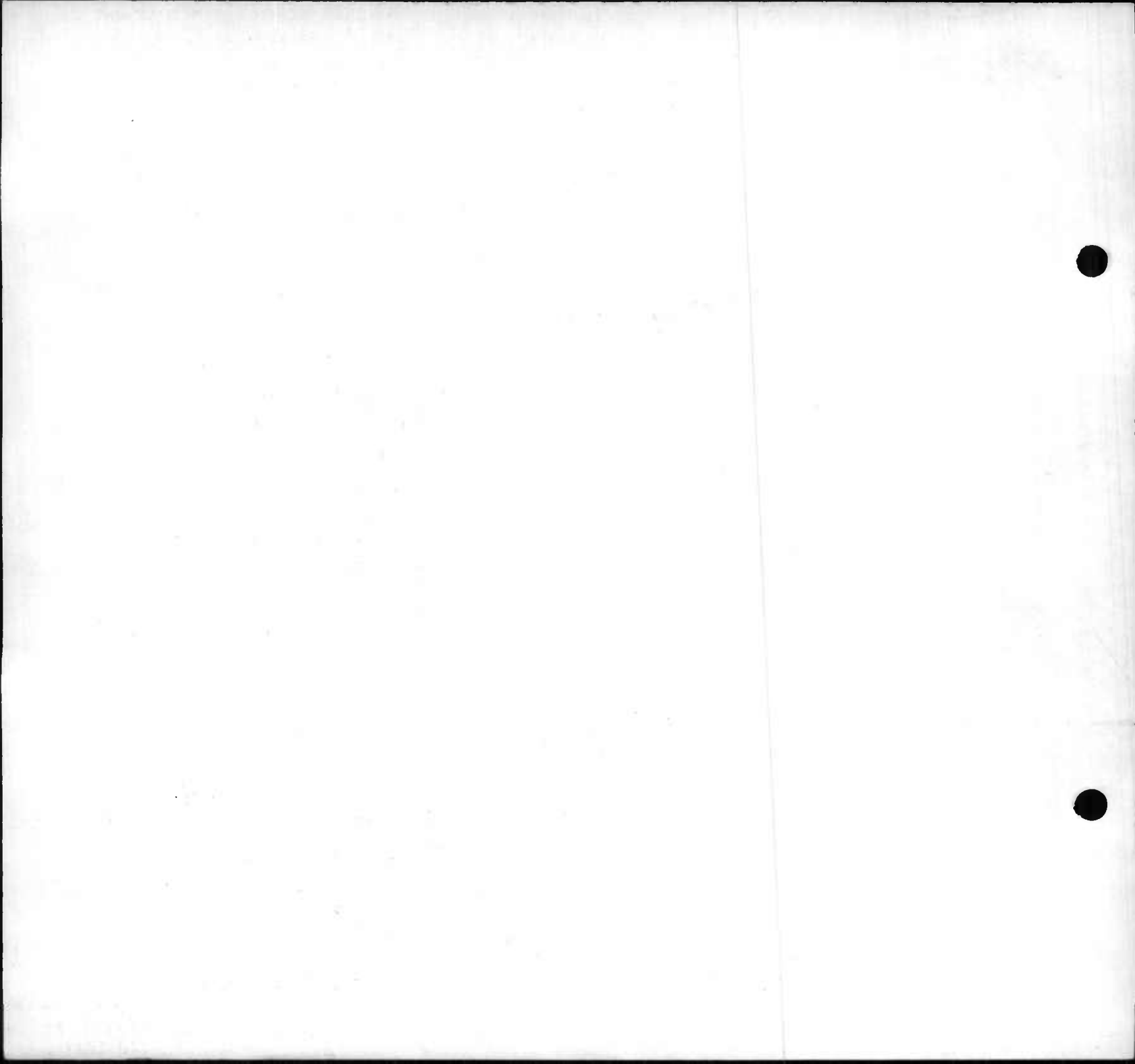
ST. AGNES HOSPITAL | | | | | A. STATE
MARYLAND | | | | |
| | | | | | B. COUNTY
BALTIMORE | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
4323 ALLAN DRIVE 21229 | | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
12-16-88 | 9. AGE (In years lost birthday)
77 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | | 10B. KIND OF BUSINESS OR INDUSTRY
B & O RAILROAD | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
MAURICE E. WASKEY | | | | | 14. MOTHER'S MAIDEN NAME
LILLY HARTMAN | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
AND CATON AVENUE
ST. AGNES HOSPITAL RECORDS - WILKENS | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
ACUTE RESPIRATORY INSUFF. PULMONARY TIBROSIS | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 18. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
MYOCARDIAL INFARCTION | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from APRIL 18 1966 to APRIL 20 1966, that (X) (we) last saw the deceased alive on APRIL 20 1966 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
M.D. <i>Amrhein</i> | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
M. AMRHEIN | | | | | 23D. ADDRESS
M.D. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4-23-66 | | 24C. NAME of CEMETERY or CREMATORY
MEADOWRIDGE CEMETERY | | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1966 | | 25B. NAME OF REGISTRAR
Robert E. Faldut | | | 25C. FUNERAL DIRECTOR
HUBBARD FUNERAL HOME | | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|--|------------------------------------|--|--|
| BIRTH NO.
66 04223 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04223 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Milford Shelton</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 2. DATE AND HOUR OF DEATH
<i>April 24, 1966</i> <i>1:15 P.M.</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
<i>Montebello State Hospital</i> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>Anne Arundel</i> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>5200</i> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<i>206 W. Arundel Road</i> | | | |
| 5. SEX
<i>M</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER-MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH
<i>8/30/09</i> | 9. AGE (In years last birthday)
<i>56</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Truck driver</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Transfer Co.</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Georgia</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA.</i> | | 13. FATHER'S NAME
<i>Thomas Shelton</i> | | | |
| 14. MOTHER'S MAIDEN NAME
<i>Bessie O'Leary</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>Unknown</i> <input checked="" type="checkbox"/> | | | |
| 16. SOCIAL SECURITY NO.
<i>Unknown</i> | | 17. INFORMANT
<i>Hospital chart</i> | | | |
| 18. <i>199-21</i> | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | INTERVAL BETWEEN ONSET AND DEATH
<i>3 years -</i> | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) <i>Squamous cell carcinoma of tongue and right palate</i> | | | |
| | | (B) <i>Cause unknown -</i> | | | |
| | | (C) <i>_____</i> | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <i>Acute chemical ulcer of stomach months</i> | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jun. 26, 1966</i> to <i>April 24, 1966</i> , that (I) (we) last saw the deceased alive on <i>April 24, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Cesar J. Pellerano</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>April 24, 1966</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Cesar J. Pellerano</i> | | 23D. ADDRESS
<i>Montebello Hospital -</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>4/26/66</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Grave Haven Lane</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Ritchie Hwy Md.</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>APR 26 1966</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Farley</i> | | 25C. FUNERAL DIRECTOR
<i>John J. Cowanston Inc.</i> | |
| | | | | ADDRESS
<i>Holling St. 25, Md.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributory cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04224 | |
|--|-------------------------|--|--------------------------------------|--|---|
| 66 04224 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) FRIEDMAN ANNA | | APRIL 22 1966 3:30 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
SINAI HOSPITAL OF BALTIMORE | | A. STATE MARYLAND
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 8206 CRANWOOD COURT | | | |
| 5. SEX
FEMALE | 6. RACE
CAUC. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
6/29/1885 | 9. AGE (In years last birthday)
80 | 10. Under 1 Yr. Months Days
11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
AT HOME | | 11. PLACE (State or foreign country)
NEW YORK, NEW YORK | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
PHILIP DORF | | | |
| 14. MOTHER'S MAIDEN NAME
MINNIE ? | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MR. SAMUEL FRIEDMAN 8206 CRANWOOD COURT | | | |
| 18. 443X1 | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) CEREBRAL THROMBOSIS | | INTERVAL BETWEEN ONSET AND DEATH
8 DAYS | |
| ANTECEDENT CAUSES | | (B) HAS CVD | | UNKNOWN | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 15, 1966 to APRIL 22, 1966 , that (I) (we) lost saw the deceased alive on APRIL 22, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Herbert Fellerman | | | | 23B. DATE SIGNED
April 22, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
HERBERT FELLERMAN | | 23D. ADDRESS
SINAI HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL
REMOVAL | | 24B. DATE
4/24/66 | | 24C. NAME OF CEMETERY or CREMATORY
CEAR PARK GROUNDS OF CLAREMORE CLUB, INC. | |
| 24D. LOCATION
CEAR PARK, NEW JERSEY | | 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1966 | | | |
| 25B. NAME OF REGISTRAR
R. E. Taylor | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | |

2

7

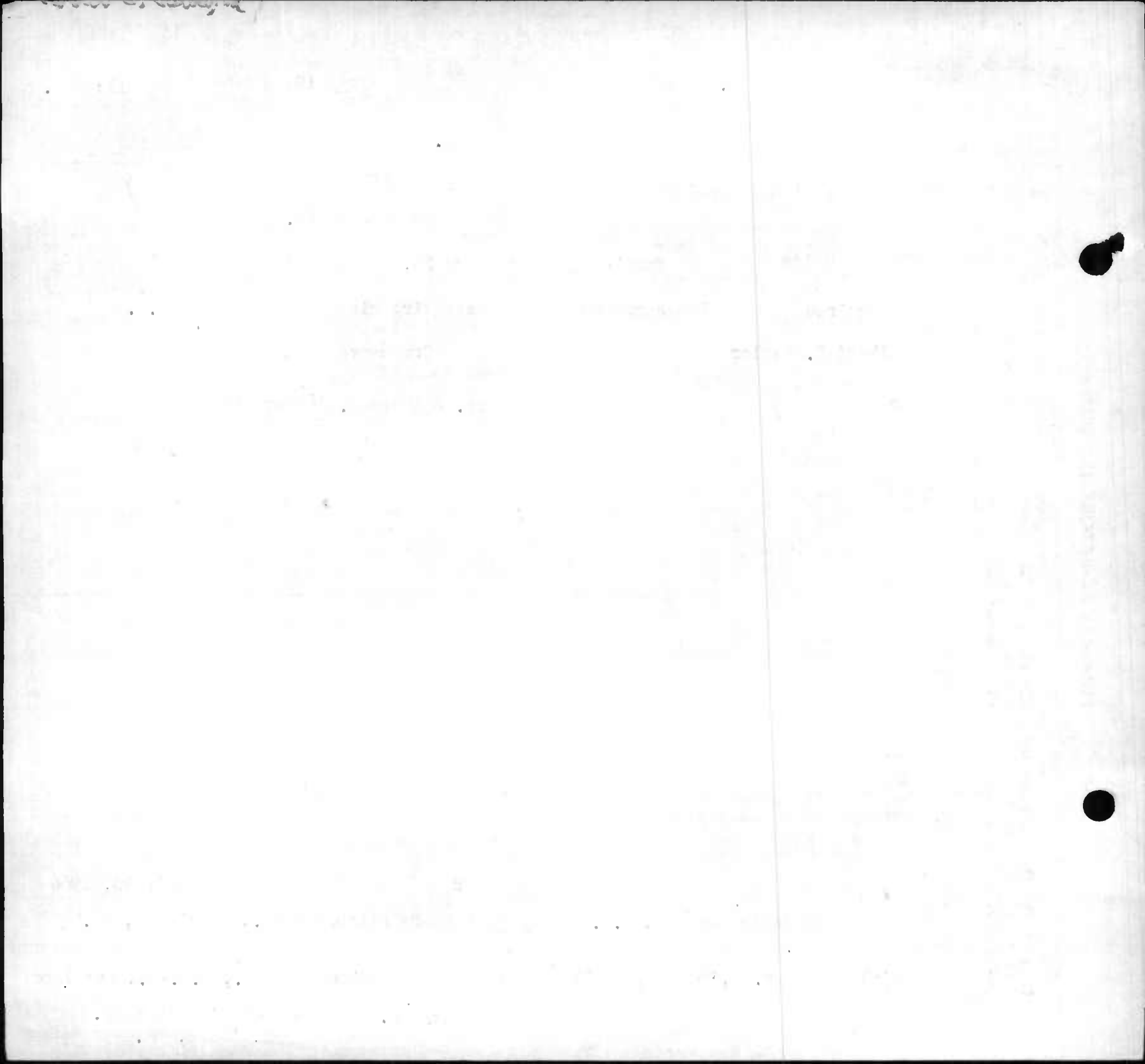


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04225 | |
|--|-------------------------|---|--|--|---|
| BIRTH NO.
66 04225 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) ROBERT C. TAYLOR | | 2. DATE AND HOUR OF DEATH
April 19, 1966 11:45 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION
South Baltimore Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY 25-84
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
3536 Seventh St. | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
June 24, 1908 | 9. AGE (In years last birthday)
57 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY
Longshoreman | | 11. BIRTHPLACE (State or foreign country)
West Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. | | 13. FATHER'S NAME
Albert C. Taylor | | | |
| 14. MOTHER'S MAIDEN NAME
Ora Hypes | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Luther F. Taylor (same) | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury at complication which caused death.)
Coronary Occlusion | | CAUSE OF DEATH
(A) DUE TO
Arteriosclerosis (CVD) | | INTERVAL BETWEEN ONSET AND DEATH
2 hours
10 years | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 21A. DATE OF OPERATION | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21C. AUTOPSY? (Yes or No) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21G. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21H. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 2 19 57 to April 19 19 66 , that (I) (we) last saw the deceased alive on April 16 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Benjamin Berdann | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
April 20, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
Benjamin Berdann, M.D. | | 23D. ADDRESS
5010A Ritchie Hwy., Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Apr. 23, '66 | | 24C. NAME OF CEMETERY or CREMATORY
Cedar Hill Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Ritchie Hwy., A.A.Co., Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1966 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR
George J. Gonce - 4001 Ritchie Hwy. Baltimore, Md. | | | |



BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

CHARLES CHALK

2. DATE AND HOUR PRONOUNCED DEAD

April 22, 1966

12:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4254 Falls Rd.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

1/7/25

9. AGE (In years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

PLUMBER

10B. KIND OF BUSINESS OR INDUSTRY

G. H. HARDESTY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

YES

WWII

16. SOCIAL
SECURITY NO.

218-14-7575

17. INFORMANT

ADDRESS

BETTY H. CHALK 4254 FALLS RD.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease with
~~recent~~ recent coronary artery thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-23-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

4/26/66

23C. NAME OF CEMETERY or CREMATORY

BALTO. NATIONAL

23D. LOCATION

(City, town, or county)

(State)

BALTO, MD.

24A. DATE REC'D BY HEALTH DEPT.

APR 26 1966

24B. NAME OF REGISTRAR

Paul E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Paul E. Taylor, M.D.

ADDRESS

3617 Chestnut St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04227 | |
|--|----------------------|---|-----------------------------------|---|---|
| BIRTH NO. 66 04227 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) EDWARD A. KELLY | | 2. DATE AND HOUR OF DEATH
24 APR 66 850 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL DR INSTITUTION
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Chase
D. STREET ADDRESS (If rural, give location)
Chase P.O. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
? 1890 | 9. AGE (In years lost birthday)
? 76 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
New Jersey | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
Kelly | | 14. MOTHER'S MAIDEN NAME
Finity | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
RECORDS: BCH 4940 Eastern Avenue 21224 | |
| 18. 5-70.2
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
RENAL SHUTDOWN | | CAUSE OF DEATH
(A) DUE TO
PERITONITIS
(B) DUE TO
BOWEL INFARCTION
(C) 8 days | | INTERVAL BETWEEN ONSET AND DEATH
1 day | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Arteriosclerotic Heart disease - Chronic | | | |
| 19A. DATE OF OPERATION
16 Apr 66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Bowel Infarct | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 16 Apr 1966 to 24 Apr 1966 that (I) was lost saw the deceased alive on 24 Apr 1966 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
David F. Fairbanks | | 23B. DATE SIGNED
24 Apr 66 | | 23C. PHYSICIAN'S NAME (Type)
DAVID F. FAIRBANKS M.D. | |
| 23D. ADDRESS
4940 Eastern Avenue
BALTIMORE CITY HOSPITALS | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | |
| 24B. DATE
4-26-66 | | 24C. NAME OF CEMETERY or CREMATORY
Sacred Heart | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1966 | | 25B. NAME OF REGISTRAR
Robert E. Fairbanks | | 25C. FUNERAL DIRECTOR ADDRESS
Walter Dobrowski 1005 Dundalk Ave | |

M
 W
 1890
 1890
 1890
 1890

RURAL SHEDS
 PERITONITIS
 POWER INFRASTRUCTURE
 WATER SUPPLY

10 Apr-90

Power Intert

NO

David F. Fairbanks
 10 Apr-90
 10 Apr-90

Baltimore City Health
 10 Apr-90
 10 Apr-90

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------------|--|---|---|--|--|---|---|--|
| 66 04228
CERTIFICATE OF DEATH | | | | | Registered No. 66 04228 | | | | |
| 1. NAME OF DECEASED
(Type or Print) Albert Whelan Mansfield | | | | | 2. DATE AND HOUR OF DEATH
April 25, 1966 2: 44 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
US Public Health Service Hospital
Wyman Pk. Drive & 31st St. | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE New Jersey
B. COUNTY Atlantic City
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Atlantic City
D. STREET ADDRESS (If rural, give location)
210 Pitney A ve. | | | | |
| 5. SEX
M | 6. RACE
col. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
3/6/36 | 9. AGE (In years last birthday)
30 | If Under 1 Yr. Months: Days: Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Painter | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Va. | | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Allen Mansfield | | | | | 14. MOTHER'S MAIDEN NAME
Katie Johnson | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes USAD 1954-1956 | | | 16. SOCIAL SECURITY NO.
154-24-2571 | | 17. INFORMANT ADDRESS
Records- US PHS Hospital, Balto, Md. | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Pulmonary insufficiency
(A) DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Massive left pleural effusion & right pulmonary edema
(B) DUE TO
Hodgkin's disease
(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH
Hours
Days
Months | | | | | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (U) (this hospital) attended the deceased from Mar. 24 19 66 to Apr. 25 19 66 , that (U) (we) last saw the deceased alive on Apr. 25 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (U) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<i>James M Weaver</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
4/25/66 | |
| 23C. PHYSICIAN'S NAME (Type)
James M. Weaver, Medical Director | | | | | 23D. ADDRESS
US PHS Hospital, Balto, Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-30-66 | | 24C. NAME OF CEMETERY or CREMATORY
Lincoln Memorial | | | 24D. LOCATION (City, town, or county) (State)
Mays Landing, N. J. | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1966 | | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR
DeBaptist Funeral Home | | | ADDRESS
1901 Artie Ave. Atlantic City, N.J. | |

210 11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

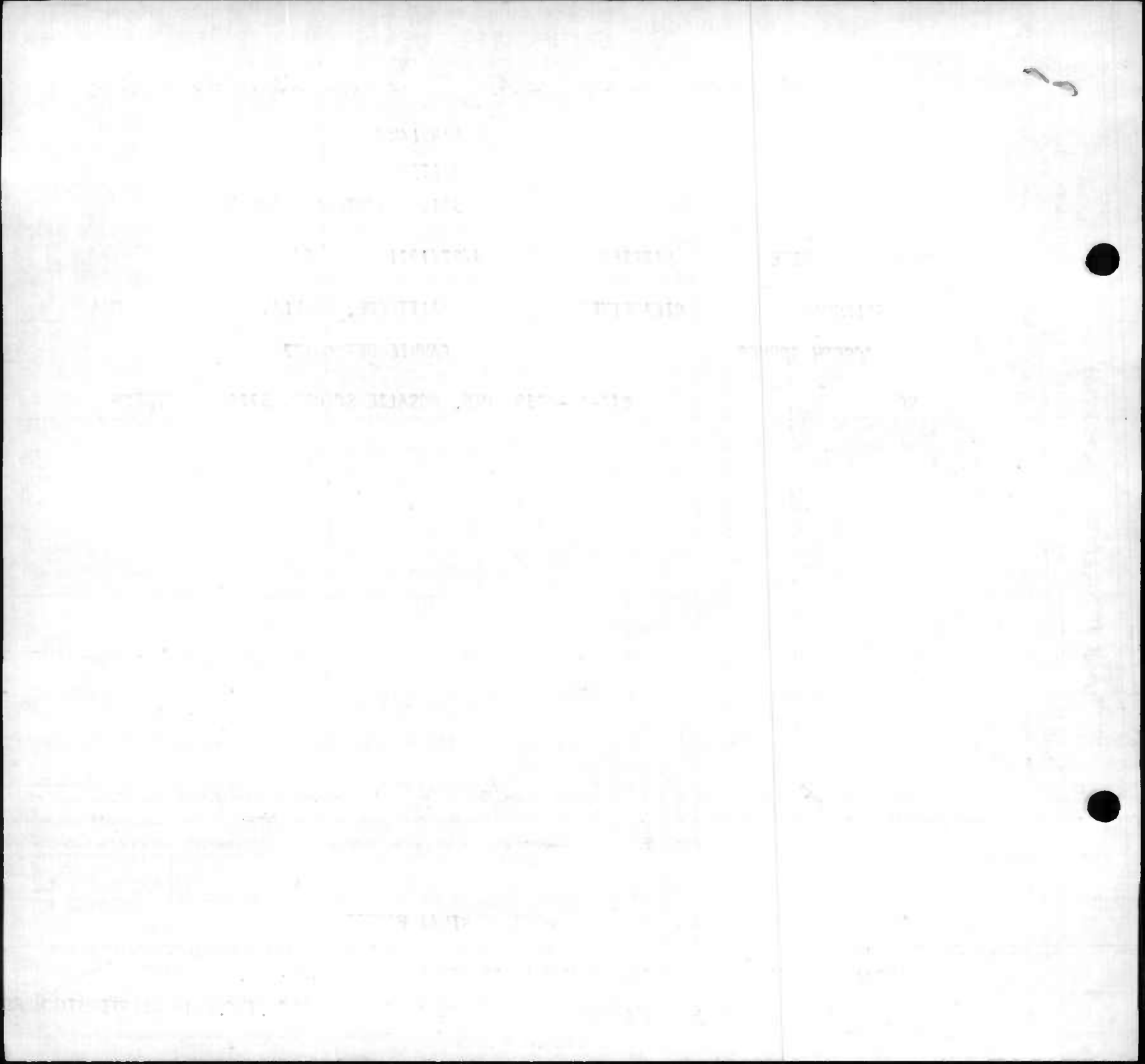
11/11/11

11/11/11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

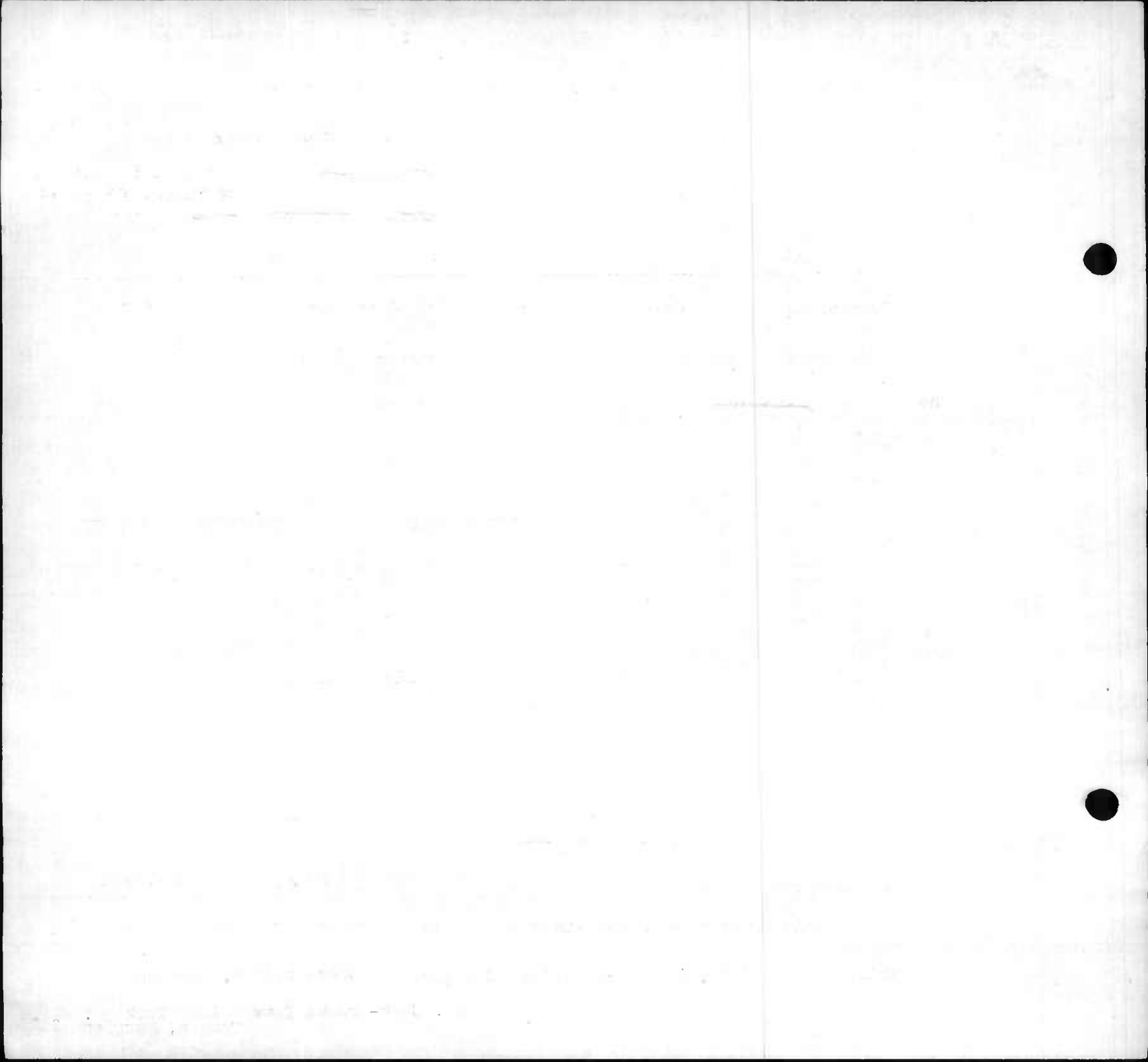
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|--|---|---|---|--|---|--|--|
| 66 04229 | | | | | 66 04229 | | | | |
| BIRTH NO. | | | | | REGISTERED NO. | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) MORRIS SOPHER | | | | | 2. DATE AND HOUR OF DEATH
APRIL 22, 1966 7:17A M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 27-19 | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
42 Sinai Hosp of Balt. | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | | |
| (If not in hospital or institution, give street address or location) | | | | | D. STREET ADDRESS (If rural, give location)
3912 W NORTHERN PARKWAY | | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
4/27/1911 | 9. AGE (In years last birthday)
54 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SALESMAN | | 10B. KIND OF BUSINESS OR INDUSTRY
CIGARETTES | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
JOSEPH SOPHER | | | | | 14. MOTHER'S MAIDEN NAME
FANNIE BERKOWITZ | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
212-10-0935 | | 17. INFORMANT
MRS. ROSALIE SOPHER | | | | ADDRESS
3912 W NORTHERN PKWY |
| 18. 7-20-1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Ante Myocardial Infarction
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
ASLVD | | | | | CAUSE OF DEATH
(A) Ante Myocardial Infarction
DUE TO
(B) ASLVD
DUE TO
(C) | | | | INTERVAL BETWEEN ONSET AND DEATH |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (if at this hospital) attended the deceased from April 22, 1966 to April 22, 1966 , that (if we) last saw the deceased alive on April 22, 1966 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (We) (did) not view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Benjamin R. Chipman | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
April 22, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
Benjamin R. Chipman | | | | | 23D. ADDRESS
SINAI HOSPITAL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/24/66 | | 24C. NAME OF CEMETERY OR CREMATORY
CHIZUK AMINO (ARLINGTON) | | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1966 | | | 25B. NAME OF REGISTRAR
Robert E. Fisher | | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | |
|---|--|---------|--|--|---|------------------|--|--|--|-----------------------------|--|--|--|--|--|
| 66 04230 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 04230 | | | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | | | | | | | |
| VICTOR SHANNON MARTIN | | | | | 4-21-66 | | | | | 9:00 AM. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | | | A. STATE | | | | | B. COUNTY | | | | | |
| UNIVERSITY HOSPITAL | | | | | MARYLAND | | | | | BALTIMORE | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | | | | | | |
| | | | | | Cockeysville | | | | | 3300 | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) | | | | | 8C WARREN LODGE COURT | | | | | |
| | | | | | | | | | | | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | | |
| M | | W | | MARRIED | | 7-20-10 | | 55 yrs | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| ENGINEER | | | | BELL TELEPHONE | | | | PENNSYLVANIA | | | | USA | | | |
| 13. FATHER'S NAME | | | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | |
| REGINALD MARTIN | | | | | | | | LYDIA DEVORE | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | |
| NO | | | | 215-10-4130 | | | | PATIENT + WIFE | | | | SAME | | | |
| 18. 356.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | (A) PARALYSIS of RESPIRATORY MUSCLES | | | | 1 day | | | |
| ANTECEDENT CAUSES | | | | | | | | (B) PROBABLE PULMONARY EMBOLIZATION | | | | 1 day | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | (C) AMYOTROPHIC LATERAL SCLEROSIS | | | | 1 1/2 YEARS | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 2 | | | | | | | | YES | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21E. INJURY OCCURRED | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | | | | | |
| 22. I certify that (he) (this hospital) attended the deceased from 3-31 1966 to 4-21 1966, that (he) (we) last saw the deceased alive on 4-21-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED | | | |
| Margaret E. Lang MD | | | | | | | | | | | | 4/21/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | | | 23D. ADDRESS | | | | | | | |
| MARGARET E. LANG, MD M.D. | | | | | | | | UNIVERSITY HOSPITAL, BALTIMORE, MARYLAND | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | | 24C. NAME OF CEMETERY or CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | | | April 23, 66 | | | | Dulaney Valley Cemetery | | | | Cockeysville, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | | 25C. FUNERAL DIRECTOR | | | | ADDRESS | | | |
| APR 26 1966 | | | | Robert E. Taylor, MD | | | | Wm. Cook-Brooks Town | | | | 1050 York Rd. Towson, Maryland 21204 | | | |



66 04231

BALTIMORE CITY HEALTH DEPARTMENT

66 04231

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CAROLINE V. THOMAS

2. DATE AND HOUR PRONOUNCED DEAD

4-25-66

2:25 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

FRANKLIN SQUARE HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1236 Lombard Street 21223

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

July 24, 1912

9. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Lampley

14. MOTHER'S MAIDEN NAME

Francis ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214-20-5625

17. INFORMANT

ADDRESS

Mr. Harry W. Thomas Sr. 1236 W. Lombard St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty infiltration of liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Carcinoma, left breast

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-25-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/28/66

23C. NAME OF CEMETERY or CREMATORY

Cedar Hill Cemetery

23D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 26 1966

Robert E. Fisher, M.D.

Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202

VALLEY POLICE

RECEIVED

APR 24 1964

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE AMENDED

| | | | | | |
|---|--|---|--|---|--|
| BIRTH NO.
66 04232 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 66 04232 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) EDWARD HEINZORLING | | 2. DATE AND HOUR OF DEATH
APRIL 23, 1966 1:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
MERCY HOSPITAL INC. | | 4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY 4-01 | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) SEP. | |
| 8. DATE OF BIRTH DEC. 17, 1909 | | 9. AGE (In years last birthday) 56 | | 10. AGE (In years last birthday) 56 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME EDWARD HEINZORLING SR. | | 14. MOTHER'S MAIDEN NAME ELLEN SAUERWEIN
SARA SAUERWEIN | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MRS. D. HAYMAN ADDRESS 8213 LACK RAVEN BLVD BALT. MD. 21204 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
HEPATIC FAILURE | | CAUSE OF DEATH
(A) HEPATIC FAILURE | | INTERVAL BETWEEN ONSET AND DEATH
4 DAYS | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
LAENNEC'S CIRRHOSIS | | (B) LAENNEC'S CIRRHOSIS | | ? 5 yrs. | |
| | | (C) CHRONIC ALCOHOLISM | | ? 30 yrs. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 20 19 66 to APRIL 23 19 66 and that (I) (we) last saw the deceased alive on APRIL 23 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Eusebio P. Gonzalez M.D. | | | | 23B. DATE SIGNED April 23/66 | |
| 23C. PHYSICIAN'S NAME (Type) EUSEBIO P. GONZALEZ M.D. | | | | 23D. ADDRESS MERCY HOSP. INC., BALTO. 2 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 4-25-66 | | 24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | |
| 24D. LOCATION (City, town, or county) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. APR 25 1966 | | | |
| 25B. NAME OF REGISTRAR G. E. F. J. J. | | 25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson 1050 York Rd. 21204 | | | |

15153

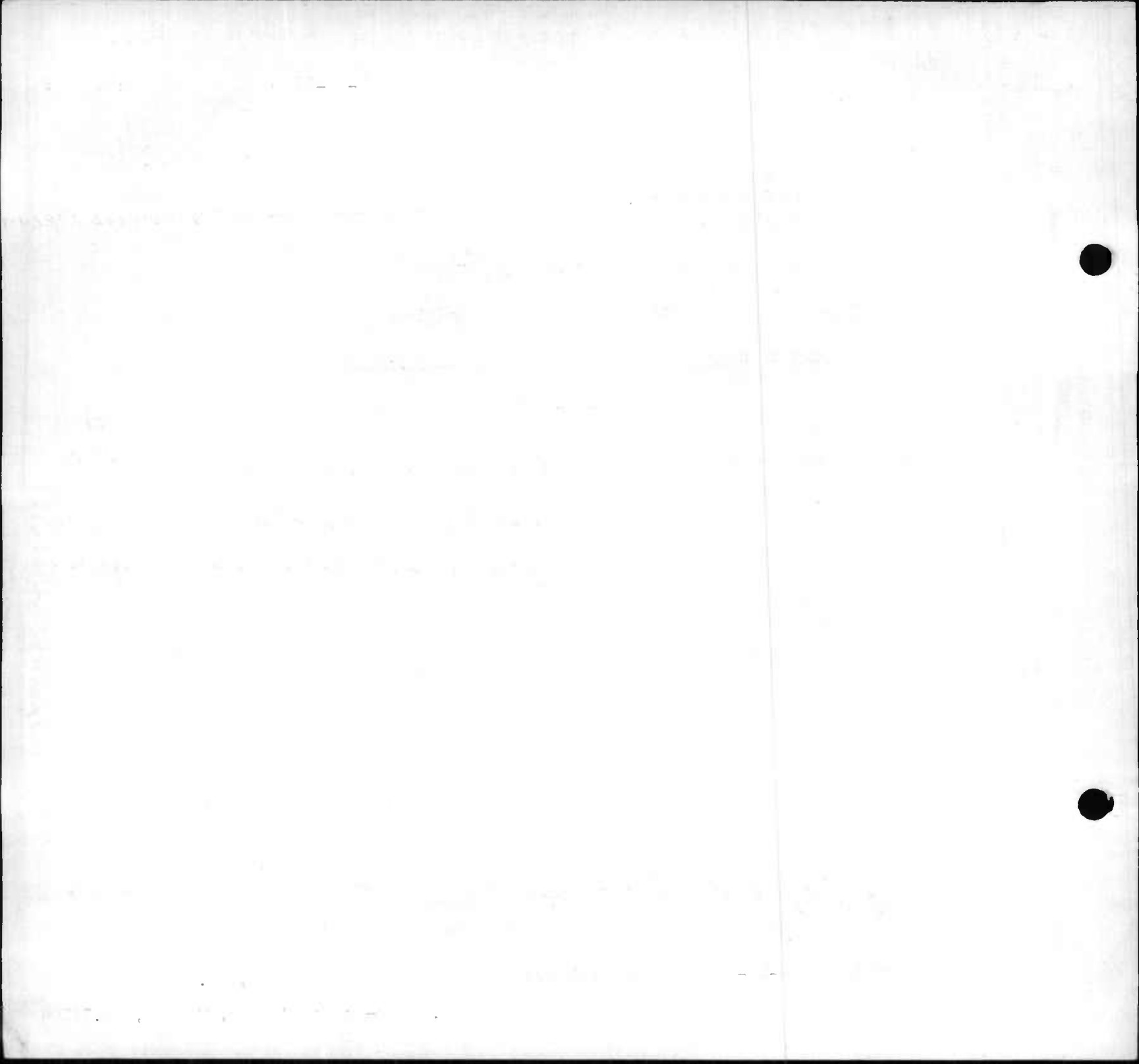
1/1/1

1/1/1

1/1/1

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 04233 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04233 | |
|---|---------------------|---|-------------------------------------|--|--|---|---|
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print)
CESSLER, Regina Catherine | | | | 4-22-66 8:40 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
JENKINS MEMORIAL HOSPITAL | | (If not in hospital or institution, give street address or location) | | A. STATE
Maryland | | B. COUNTY | |
| 1000 S Caton Ave. | | Baltimore, Md. 21229 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | D. STREET ADDRESS (If rural, give location)
106 Woodlawn Rd. 517 WINDWOOD PARKWAY | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Never married | 8. DATE OF BIRTH
6-4-1898 | 9. AGE (In years last birthday)
67 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 11. BIRTHPLACE (State or foreign country)
Baltimore |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY
City of Balto | | 11. BIRTHPLACE (State or foreign country)
Baltimore | | 12. CITIZEN OF WHAT COUNTRY?
Yes | |
| 13. FATHER'S NAME
JOHN J GESSLER | | | | 14. MOTHER'S MAIDEN NAME
JANE CANTON | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
214-40-2651 A | | 17. INFORMANT
MEDICAL RECORDS ROOM | | ADDRESS | |
| 18. 331X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
ANTecedent CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) Cerebral Vascular Acc.
DUE TO
(B) cerebral arteriosclerosis
DUE TO
(C) generalized arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
2 wks
year
year | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/9 1963 to 4/22 1966 , that (I) (we) last saw the deceased alive on 4/22 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
J. Raymond Gladue | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/22/66 | |
| 23C. PHYSICIAN'S NAME (Type)
J. Raymond Gladue | | | | 23D. ADDRESS
Jenkins Memorial Hospital 21229 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-25-66 | | 24C. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1966 | | 25B. NAME OF REGISTRAR
Robert E. Falcione | | 25C. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, Towson, Md. 21204 | | ADDRESS | |



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FORREST LEE CARSON

2. DATE AND HOUR PRONOUNCED DEAD

April 22, 1966

6:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

400 W. Calvert St.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

8/30/20

9. AGE (in years
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Seaman

10B. KIND OF BUSINESS OR INDUSTRY

Merchant Marine

11. BIRTHPLACE (State or foreign country)

Iredell Co., N.C.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Julian T. Carson

14. MOTHER'S MAIDEN NAME

Laura J. Carrigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Nicholson Funeral Home Statesville, N.C.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gastro-intestinal hemorrhage
DUE TO cirrhosis of the liver

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Congestive heart failure

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-23-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/27/66

23C. NAME of CEMETERY or CREMATORY

Pilgrim Cemetery

23D. LOCATION (City, town, or county) (State)

Statesville, N.C.

24A. DATE REC'D BY HEALTH DEPT.

APR 26 1966

24B. NAME OF REGISTRAR

R. E. Farley, M.D.

24C. FUNERAL DIRECTOR ADDRESS

1217 St. Paul St.
Wm. Cook-Brooks Inc. Baltimore, Md.

WALLIS V. FORTGIE

PAGE 2

1941

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|---|--|--|-----------------------------|--|---|--|---|---|---|--|--|
| 66 04235
CERTIFICATE OF DEATH | | | | | Registered No. 66 04235 | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Mrs Julia Skarbek | | | | | 2. DATE AND HOUR OF DEATH
April 24, 1966 12 50 P.M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md. B. COUNTY 1102 | | | | | | |
| 5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | | | | | 8. DATE OF BIRTH
1/7/1878 | | 9. AGE (In years last birthday) 91 | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country)
Poland | | 12. CITIZEN OF WHAT COUNTRY? ? | |
| 13. FATHER'S NAME
Thomas Ciminski | | | | | 14. MOTHER'S MAIDEN NAME
Mary | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | | 16. SOCIAL SECURITY NO.
220-09-6753 | | 17. INFORMANT
Josephine Sharoky 3730 Offutt Rd. Randlestown Md. | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
433.1 I
Cerebral Vascular Thrombosis | | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO
ASCVD & Atrial Fibrillation, IVCD & probable RBBB + LBBB | | | | | INTERVAL BETWEEN ONSET AND DEATH
unk. | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that the (this hospital) attended the deceased from April 23 19 66 to April 24 19 66 , that the (we) last saw the deceased alive on April 24 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Wm Gregory Bruce M.D. | | | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
April 24, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
Wm. Gregory Bruce M.D. | | | | | | | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 24B. DATE
4/27/66 | | 24C. NAME OF CEMETERY OR CREMATORY
Holy Rosary | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1966 | | | | | 25B. NAME OF REGISTRAR
Robert E. Farley | | | 25C. FUNERAL DIRECTOR
1217 St. Paul St. ADDRESS Wm. Cook-Brooks Inc Baltimore, Md. 21202 | | | |

Mary Hospital

W

Widowed

Ciminski

Thomas

Poland

Mary

808 St Paul St
Baltimore

1/1/1878

Carroll County, Maryland
ASD 5 April 1900
Baltimore

No

New County Bank

X

April 24
April 23
April 22

April 24

1

66 04236

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 04236

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROSE MARIE SANTINI

2. DATE AND HOUR PRONOUNCED DEAD

April 16, 1966 2:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

55 S. Monroe Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Dec. 4, 1939

9. AGE (In years
last birthday)

26

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harvey S. Sollenberger

14. MOTHER'S MAIDEN NAME

Ota (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216-36-4826

17. INFORMANT

Guillermo P. Santini

ADDRESS A P O 96307

San Francisco, Calif.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Multiple Traumatic Injuries.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

Lexington St. & Park Avenue

21D. TIME OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

4 16 '66 P

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Jumped from 6th floor window of store.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
4/17/6623A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Apr. 26, 1966

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

Baltimore

(City, town, or county)

(State)

Maryland

24A. DATE REC'D BY HEALTH DEPT.

APR 26 1966

24B. NAME OF REGISTRAR

Wm. Cook-Brooks, Inc.

24C. FUNERAL DIRECTOR

Wm. Cook-Brooks, Inc.

ADDRESS

1217 St. Paul Street

WALLACE JORDON

PAID 10/10/10

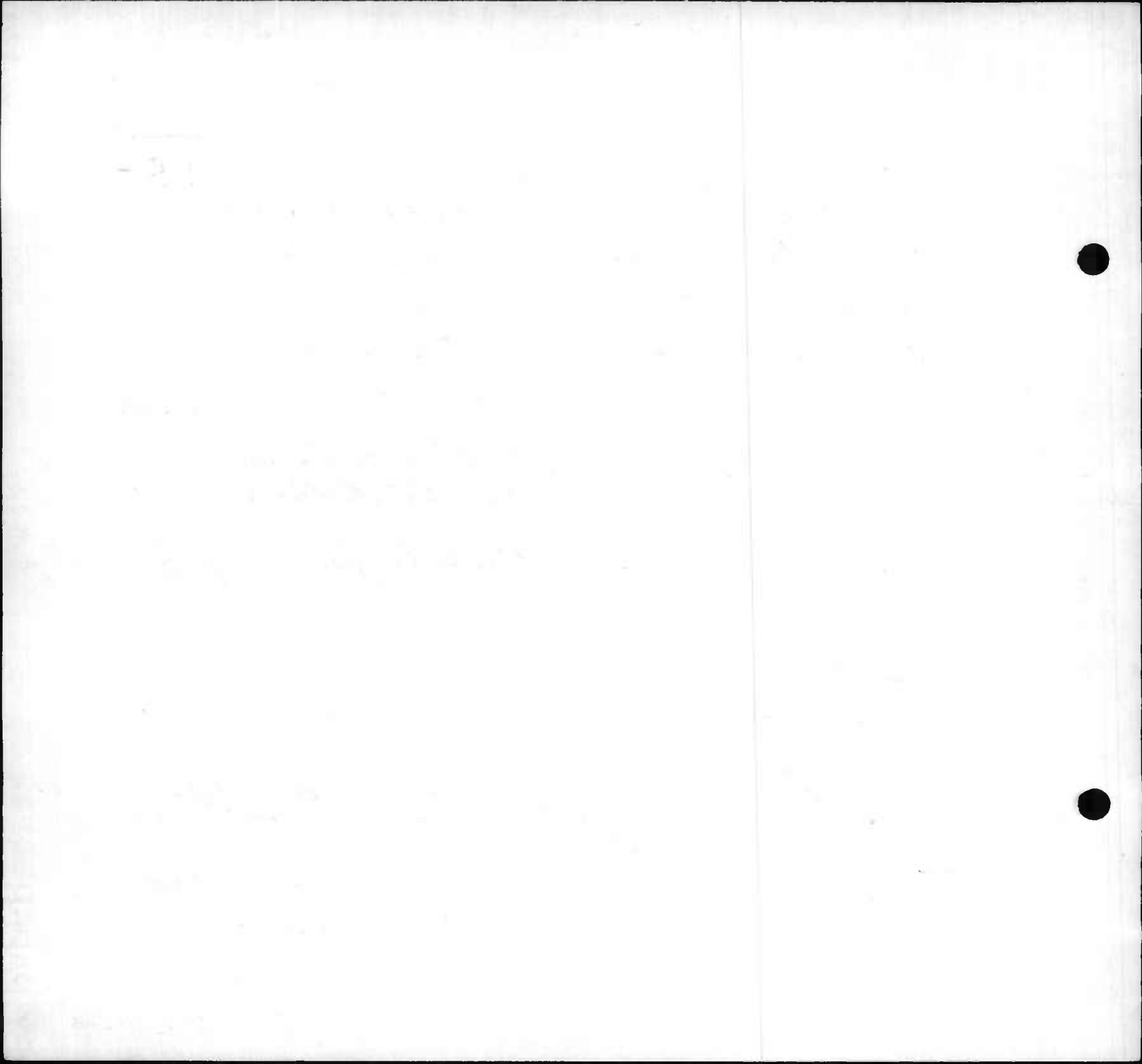
10/10/10

10/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04237 | |
|---|---------|--|--------------------------|---|------------------------------|
| 66 04237 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | LUKA PEREZ | | 23 APR 66 6 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | |
| UNIVERSITY of Maryland Hosp | | | | Maryland Baltimore City | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| | | | | BALTIMORE 15-06 | |
| | | | | D. STREET ADDRESS (If rural, give location) | |
| | | | | 2929 W. North Ave | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| F | N | WIDOW | 1-1-1901 | 65 | USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | Home | | George Town, S.C. | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| MOUTRIC-Smuck | | | SARIE Wallace | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 19-01-4310A | | Mrs. B. HARRIS 1624 Abbotson | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | |
| | | | | ASHD + Chronic Bronchitis | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | |
| | | | | Dehydration, Gout, (12) Hallux | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 4/21 1966 to 4/23 1966, that (1) (we) last saw the deceased alive on 4/22 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Michael B. Flynn M.D. | | | | 23 APR 66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| MICHAEL B. FLYNN M.D. | | | | Clare Hosp | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 4-26-66 | | MT. CALVARY | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| APR 26 1966 | | G. E. Johnson | | Morton & Pyett 1701 LAURENS | |



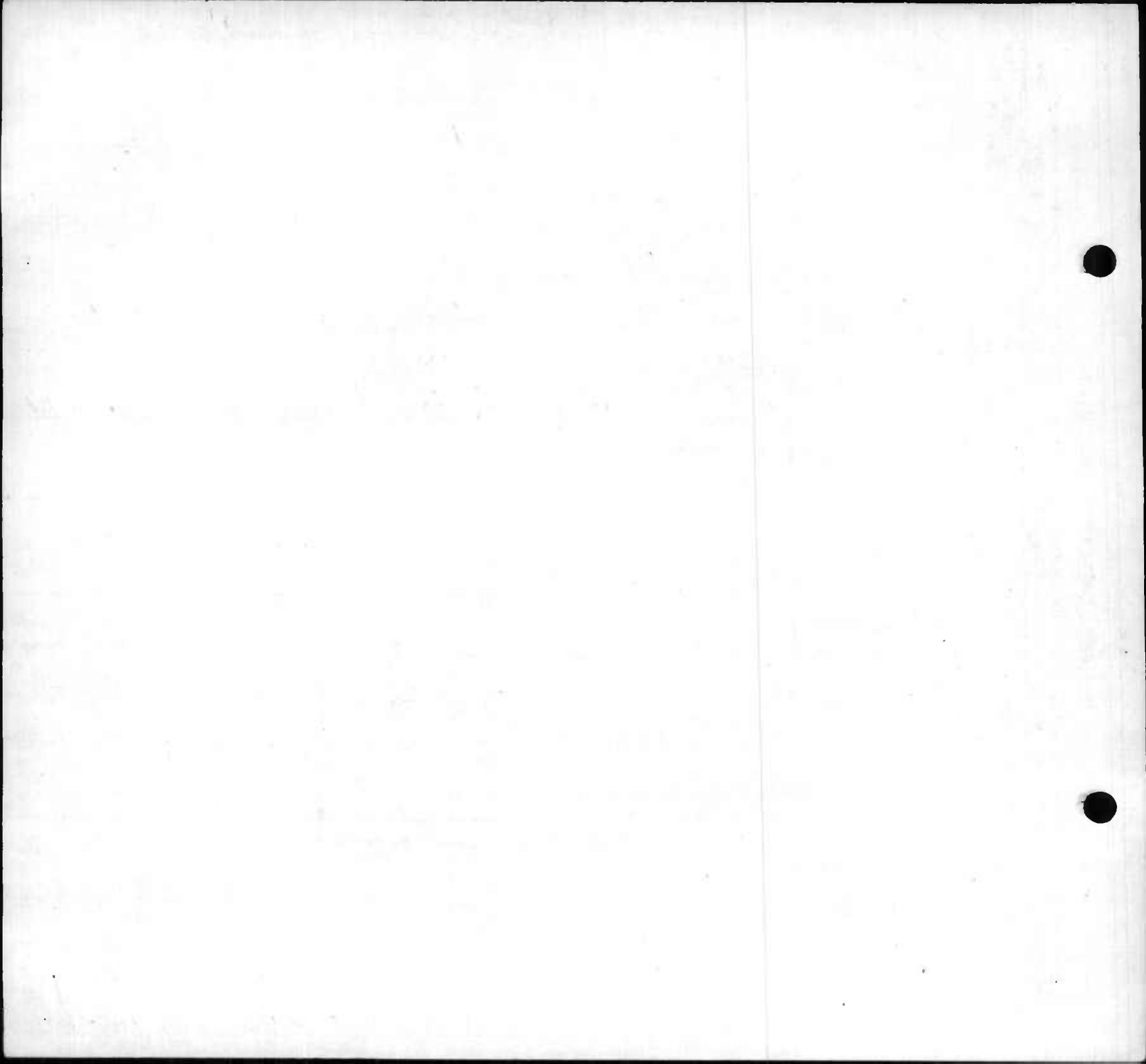
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|--|--|--|--|--|------------------------------------|---|--|
| 66 04238
CERTIFICATE OF DEATH | | | | | Registered No. 66 04238 | | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>ELIZABETH STEVENSON</i> | | | | | 2. DATE AND HOUR OF DEATH
<i>4/21/66 7:30 A.M.</i> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>36 FRANKLIN SQUARE Hosp.</i> | | | | | A. STATE
<i>Md.</i> | | | | |
| | | | | | B. COUNTY
<i>4-02</i> | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | | | | | D. STREET ADDRESS (If rural, give location)
<i>6210 Forney Alley</i> | | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>Negro</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>UNK.</i> | | 8. DATE OF BIRTH
<i>UNK.</i> | 9. AGE (In years last birthday)
<i>89</i> | If Under 1 Yr. Months: Ooys: Hours: Min. | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>UNK.</i> | | 11. BIRTHPLACE (State or foreign country)
<i>UNK.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | |
| 13. FATHER'S NAME
<i>UNK.</i> | | | | | 14. MOTHER'S MAIDEN NAME
<i>UNK.</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO.
<i>UNK.</i> | | 17. INFORMANT ADDRESS
<i>Lincoln Nursing Home Balto. Md</i> | | | | |
| 18. <i>490X1</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

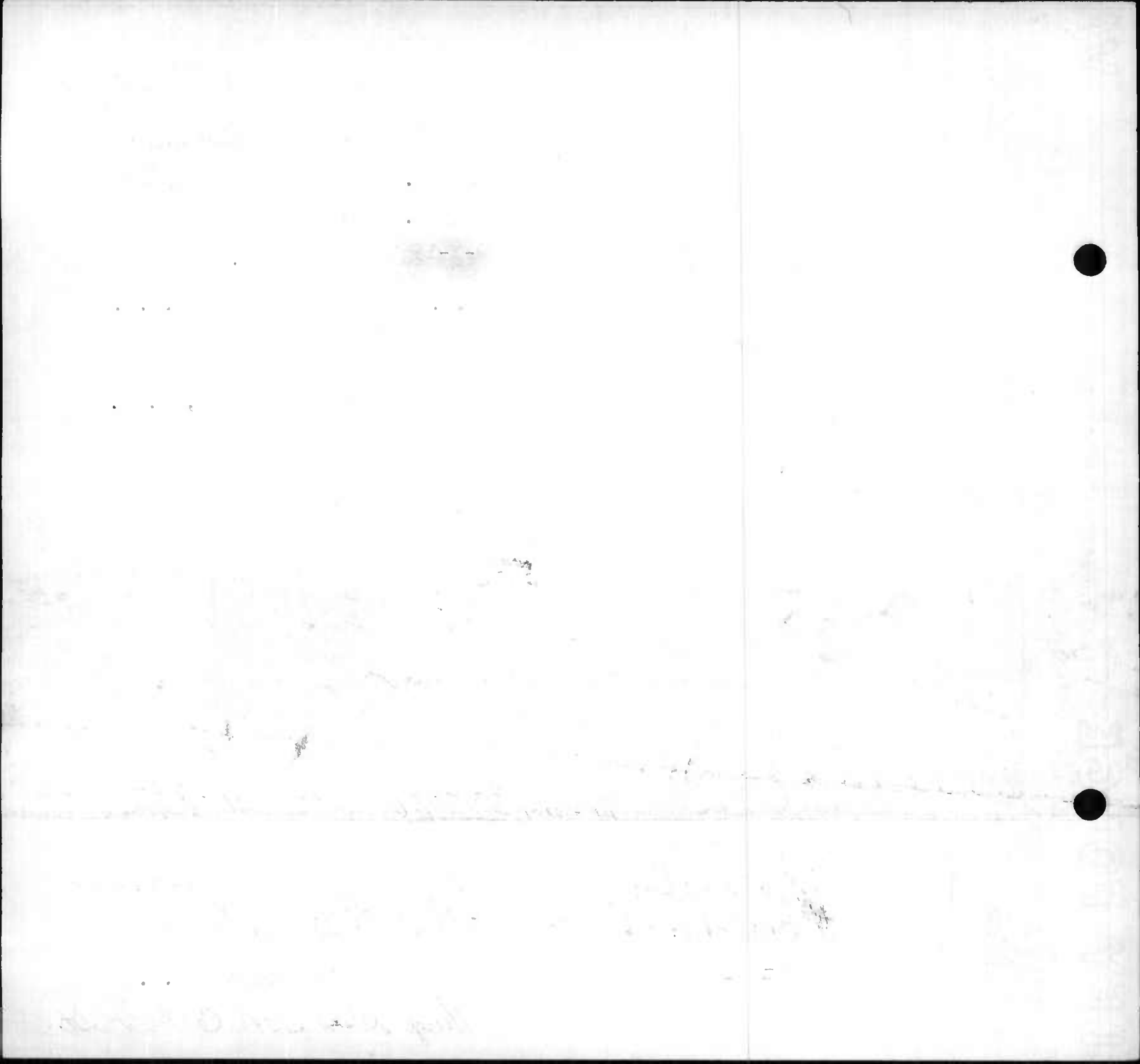
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH
(A) <i>Bit. pneumonia</i>
DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH
<i>2 days</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4/21/66</i> 19 to <i>4/21/66</i> 19 that (I) (we) last saw the deceased alive on <i>4/21/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<i>S. MUNESES</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>4/21/66</i> | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>S. MUNESES</i> | | | | | 23D. ADDRESS
M.D. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 24B. DATE
<i>4-22-66</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>MT. CALVARY</i> | | 24D. LOCATION (City, town, or county)
<i>A.A. Co. Md.</i> | | 24E. LOCATION (City, town, or county) (If not in Baltimore City, give exact location) | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>APR 26 1966</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Farley, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>Morton DyeTT</i> | | 25D. ADDRESS
<i>1701 LAURENS</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04239 | |
|--|---------------|---|-------------------------|--|--|
| BIRTH NO. 66 04239 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Ernest Green | | 2. DATE AND HOUR OF DEATH 4-24-66 9:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 543 N. Carey St. Baltimore, Md. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 Provident Hospital. 1514 Division St. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. | | D. STREET ADDRESS (If rural, give location) 543 N. Carey Street | |
| 5. SEX M. | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 9-8-15 | 9. AGE (In years last birthday) 50 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) S.C. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Zicem Green | | 14. MOTHER'S MAIDEN NAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 217-01-0437 | | 17. INFORMANT ADDRESS Dorothy Green Sumpter, S. C. | |
| 18. 341.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO Nephrosis & Anemia (B) DUE TO Duodenal Ulcer - Perforated 28 days (C) | | INTERVAL BETWEEN ONSET AND DEATH 3 wks | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 4-5-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Duodenal Ulcer | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 3-28-66 1966 to 4-24-66 1966, that (I) (we) last saw the deceased alive on 4-24-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE I. Bradshaw Higgins M.D. | | 23B. DATE SIGNED 4-24-66 | | 23C. PHYSICIAN'S NAME (Type) I. Bradshaw Higgins M.D. | |
| 23D. ADDRESS 2243 Madison Ave. | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5-1-66 | |
| 24C. NAME OF CEMETERY OR CREMATORY Church Cemetery | | 24D. LOCATION (City, town, or county) Kingstreet S.C. | | (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 26 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR George Nelson 1348 Calhoun St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04240 | |
|--|------------------------|--|---------------------------------------|--|---|
| BIRTH NO. 66 04240 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Hattie Kelly Glascoe | | | |
| 2. DATE AND HOUR OF DEATH | | April 22, 1966 17³⁰ A. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Maryland B. COUNTY 6-04 | | | |
| Home - 12 N. Durham St. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 12 N. Durham St. | | | |
| 5. SEX Female | 6. RACE Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Nov. 17, 1896 | 9. AGE (In years last birthday) 69 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Baltimore Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Charles H. Kelly | | 14. MOTHER'S MAIDEN NAME Marjoh Hechett | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 4-20-11 I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) Myocardial Infarction | | Instant | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (B) Arteriosclerosis | | ? | |
| ANTECEDENT CAUSES | | (C) | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-29-1966 to 4-22-1966 , that (I) (we) lost saw the deceased alive on 4-5-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Eugene H. Owens M.D. | | | | 23B. DATE SIGNED 4-25-66 | |
| 23C. PHYSICIAN'S NAME (Type) Eugene H. Owens M.D. | | | | 23D. ADDRESS 1735 E. Federal St | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5-26-66 | | 24C. NAME of CEMETERY or CREMATORY MT. Calvary Cem. | |
| 24D. LOCATION (City, town, or county) Brocklyn, Md. | | 24E. DATE REC'D BY HEALTH DEPT. APR 26 1966 | | 24F. NAME OF REGISTRAR Robert E. Fairbank | |
| 24G. FUNERAL DIRECTOR Clay O. Wilson | | 24H. ADDRESS 1000 Brantly Ave. | | | |

210200

10-10-57

Myocardial Infarction

Arteriosclerosis

5-29-58

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04241BIRTH NO. 66 04241

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ARTHUR M. MEADERS

2. DATE AND HOUR PRONOUNCED DEAD

April 19, 1966 7:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

LUTHERAN HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3909 Dolfield Ave.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

April 28-1944

9. AGE (in years
last birthday)

18

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James T. Meaders

14. MOTHER'S MAIDEN NAME

Dolley Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, as or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

Dolley Lewis

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of chest
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

In front of 1561 N. Fulton Ave.

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

4-19-66 7:40 P.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot in chest

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-20-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4-25-66

23C. NAME OF CEMETERY or CREMATORY

Mt Arden Cmt

23D. LOCATION

(City, town, or county)

Balto Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 26 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Choy O. Wilson 1000 Brantly St

ADDRESS

VALLEY FORGE

Handwritten notes in the upper left quadrant, including the word "VALLEY" and "FORGE".

Handwritten notes at the bottom of the page, including the word "VALLEY" and "FORGE".

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

William RASH

2. DATE AND HOUR PRONOUNCED DEAD

4/23/66

10 p

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hosp. (DOA)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

10 N. Clinton Street

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

6/27/1921

9. AGE (In years
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Guard

10B. KIND OF BUSINESS OR INDUSTRY

Anchor Freight & Motor Co., Trappe, Md.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Rash

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WW17

16. SOCIAL
SECURITY NO.

unknown

17. INFORMANT

ADDRESS

Mrs. LaVerne J. Rash 10 N. Clinton St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S Rudiger Breitenecker
NAME (Type)

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/24/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/27/66

23C. NAME OF CEMETERY or CREMATORY

Baltimore National Cemetery Baltimore, Md.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 26 1966

R. E. Farley, M.D.

John A. Moran, Inc. 3000 E. Baltimore St.

WALLER PAPER

AND CONTAINER

12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>66 04243</u> | |
|--|-------------------------|---|--------------------------------------|---|--|--|------------------------------|
| BIRTH NO. <u>66 04243</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>John W. Scott</u> | | 2. DATE AND HOUR OF DEATH
<u>April 23, 1966</u> <u>10</u> <u>00</u> <u>A</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Mercy Hospital, Inc.</u>
<u>Baltimore, Md.</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Md</u> B. COUNTY <u>1104</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u>
D. STREET ADDRESS (If rural, give location)
<u>1321 Eutan Place, #17</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>Negro</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Widowed</u> | 8. DATE OF BIRTH
<u>4/24/1890</u> | 9. AGE (In years last birthday)
<u>75</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Waiter</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Hotel</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>John S. Scott</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Laura Cooper</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>056-12-4682</u> | | 17. INFORMANT
<u>Mrs. Mae Hill-3501 Holmes Ave.</u> | | ADDRESS | |
| 18. <u>5-27-11</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) <u>Bronchopneumonia</u>
DUE TO <u>bilateral</u>
(B) <u>Emphysema</u>
DUE TO <u>?</u>
(C) <u>Generalized arteriosclerosis</u>
DUE TO <u>?</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>48 hrs.</u>
<u>?</u>
<u>?</u> | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <u>this hospital</u> attended the deceased from <u>April 21, 1966</u> to <u>April 23, 1966</u> , that <u>we</u> last saw the deceased alive on <u>April 23, 1966</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (d) <u>did</u> (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Wm Gregory Bruce</u> M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>April 23, 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>William Gregory Bruce</u> M.D. | | | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/28/66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Arbutus Memorial Pk.</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore Co. Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR
<u>Herbert E. Nutter -3035 W. North Ave.</u> | | ADDRESS | |

1

Harvey Hospital, Inc.
Baltimore, Md.

Miss Mary
Baltimore

John S. Scott

Baltimore
1321 Eastern Ave., N.W.

Wash. D.C.

James Cooper
Maryland

Yes

April 23

James Cooper

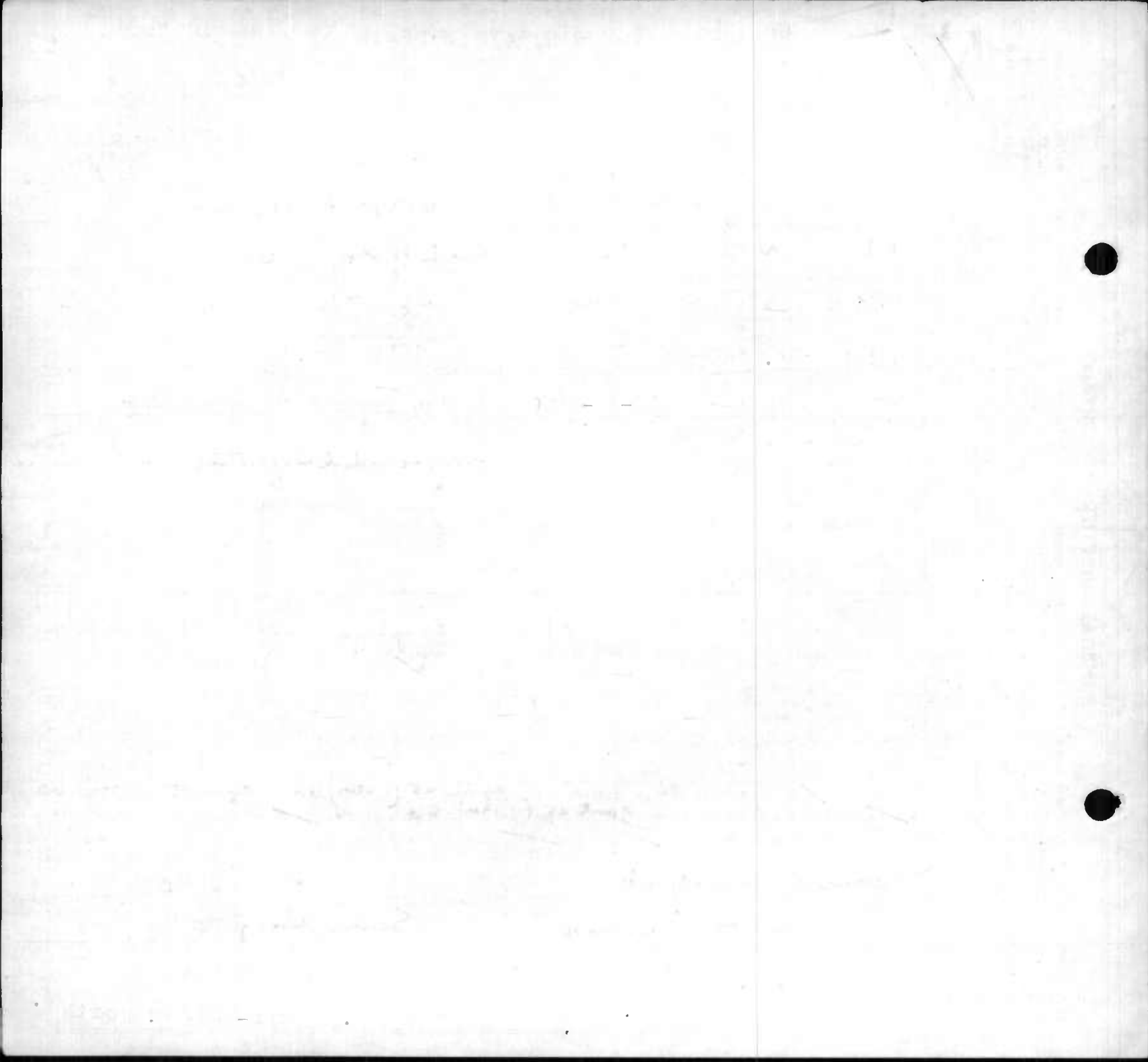
X

April 23

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|----------------------|---|---|--|--|
| BIRTH NO.
66 04244 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 66 04244 | |
| 1. NAME OF DECEASED
(Type or Print) <u>James Scott</u> | | | 2. DATE AND HOUR OF DEATH
<u>4-25-66</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Simon Hospital</u>
<u>Baltimore, Maryland</u> | | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | |
| | | | D. STREET ADDRESS (If rural, give location)
<u>6238 Falls Rd</u> | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>NC</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>M</u> | 8. DATE OF BIRTH
<u>March 18, 1898</u> | 9. AGE (In years lost birthday)
<u>68</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Custodian</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Valley Mart</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore Maryland</u> | |
| 13. FATHER'S NAME
<u>William W. Scott</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Henrietta Green</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>-</u> | | 16. SOCIAL SECURITY NO.
<u>216-24-5070</u> | | 17. INFORMANT
<u>Louise Scott 6238 Falls Road</u> | |
| 18. <u>420.11</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
<u>Myocardial Infarction</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>12 hours</u> | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO
(B) DUE TO
(C) DUE TO | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>Chronic Emphysema</u> | | | <u>Unknown</u> | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>-</u> | | 20A. AUTOPSY? (Yes or No)
<u>✓</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<u>-</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<u>-</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
<u>-</u> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
<u>-</u> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<u>-</u> | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>April 25 (1:45 AM) 1966</u> to <u>April 25 (11:19 AM) 1966</u> , that (I) (we) last saw the deceased alive on <u>April 25 (11:19 AM) 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Terren M. Himelfarb</u> | | | | 23B. DATE SIGNED
<u>April 25, 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>TERREN M. HIMELFARB</u> | | | | 23D. ADDRESS
<u>Simon Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/29/66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Carver Memorial Park</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State)
<u>Laurel Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 26 1966</u> | | 25B. NAME OF REGISTRAR
<u>Herbert E. Nutter-3035 W. North Ave.</u> | | 25C. FUNERAL DIRECTOR
<u>Herbert E. Nutter-3035 W. North Ave.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 04245 | |
|---|---------------------|---|--|---|--|--|--|
| BIRTH NO. 66 04245 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Smith, Addie</u> | | 2. DATE AND HOUR OF DEATH
<u>4/25/66</u> <u>12⁴⁵</u> <u>A.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>3801</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Johns Hopkins Hospital</u> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | | |
| D. STREET ADDRESS (If rural, give location)
<u>293 Balboa Court</u> | | | | | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>C</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>WIDOWED</u> | | 8. DATE OF BIRTH
<u>73</u> | 9. AGE (In years last birthday)
<u>73</u> | 10. If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Reverent</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign, country)
<u>Frederick Md</u> | |
| 13. FATHER'S NAME
<u>ANDREW WADE</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>UNKNOWN</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
<u>217-26-0600</u> | | 17. INFORMANT
<u>Husband</u> ADDRESS <u>SAME</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>491X I</u>
<u>Staphylococcal pneumonia</u> | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | | |
| INTERVAL BETWEEN ONSET AND DEATH
<u>4 hr.</u> | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>Ischemic cadaver, corrected</u> | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/22</u> 19 <u>66</u> to <u>4/25</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/25</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>J. R. Spencer</u> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
<u>J. R. SPENCER</u> | | | | 23D. ADDRESS
<u>Johns Hopkins Hospital</u> M.D. <u>601 N. BROADWAY 21205</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/28/66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Mt Auburn</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 26 1966</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Fadden, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Brooks Ruggold</u> | | ADDRESS
<u>1463 N. Carroll St</u> | |

Staphylococcus aureus

Staphylococcus aureus

Staphylococcus aureus

Staphylococcus aureus

Staphylococcus aureus

Staphylococcus aureus

Staphylococcus aureus

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 04246 | |
|---|-------------------------|---|-------------------------------|--|--|---|---|
| BIRTH NO.
66 04246 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print)
George Waters | | 2. DATE AND HOUR OF DEATH
April 21, 1966 1:50 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital
1514 Division Street
Baltimore, Maryland | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY 14-00
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1714 Etting Street | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
63 | 9. AGE (In years last birthday)
63 | If Under 1 Yr. Months: Days: Hours: Min. | | 10. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10B. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
217-20-8305 | | 17. INFORMANT
Walter Smith | | ADDRESS
Same | |
| 18. 500X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
Acute membranous hemorrhagic tracheobronchitis; Hemorrhagic bronchopneumonia; Pulmonary edema - marked bilateral congestion. | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
marked lateral lumbosacral lesions
Focal mucosal hemorrhage of stomach... | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 21, 1966 to April 21, 1966 , that (I) (we) last saw the deceased alive on April 21, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
D.R. Theodore | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
April 22, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
Roger Theodore | | | | 23D. ADDRESS
M.D. 1514 Division Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/26/66 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Calvary Cemetery | | 24D. LOCATION (City, town, or county) (State)
A A County Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1966 | | 25B. NAME OF REGISTRAR
R. E. Taylor | | 25C. FUNERAL DIRECTOR
Adolphus Halstead | | ADDRESS
1206 W North Ave | |

1914 Division Street
Baltimore, Maryland

43

Single

Negro

Male

North Carolina

None

None

Unknown

Unknown

Walter Smith

Yes

April 21, 1914

66

April 21, 1914

April 21, 1914

66

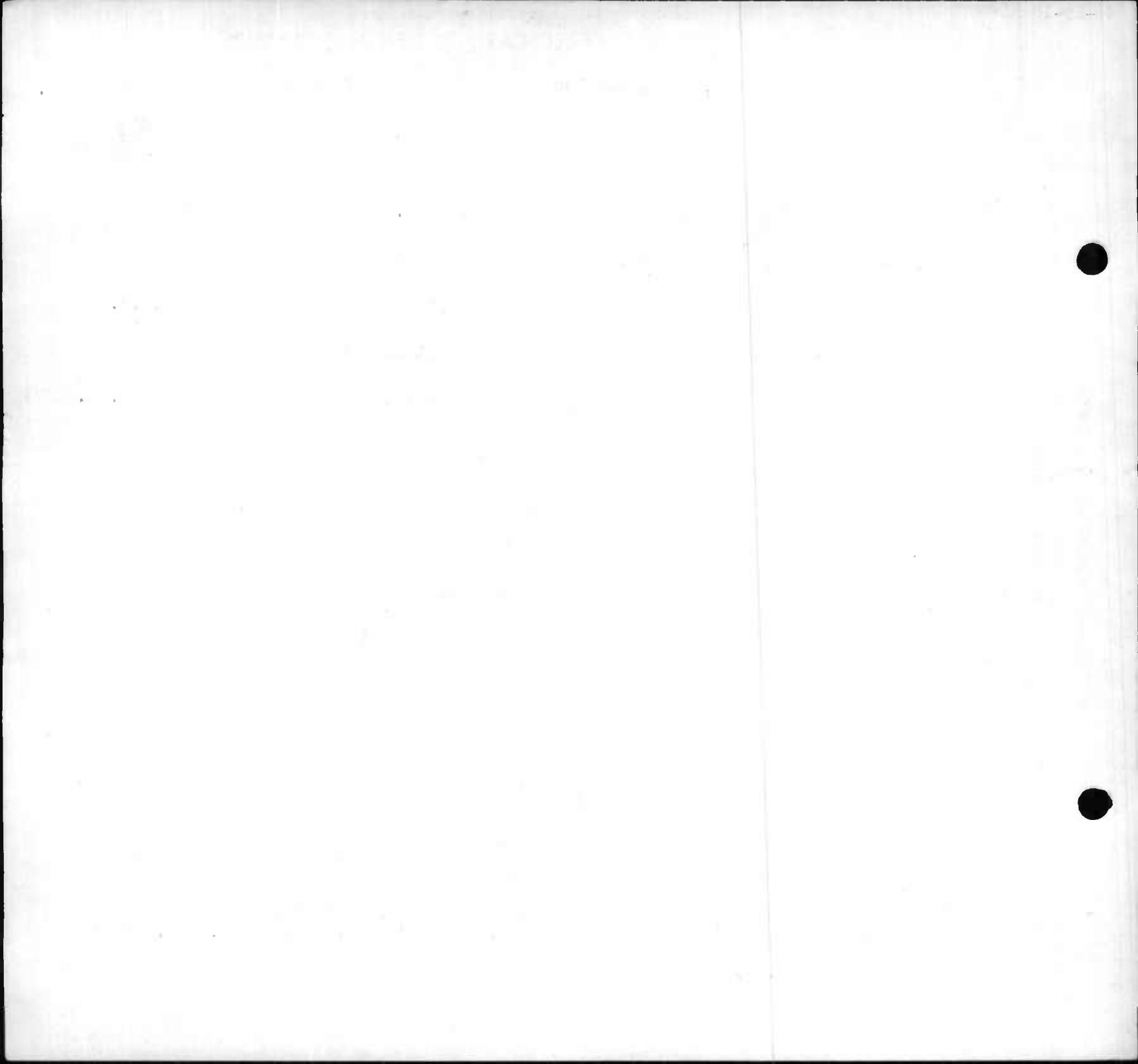
X

1914 Division Street

1914 Division Street

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04247 | |
|---|---------------|--|--------------------------|--|---|
| BIRTH NO. 66 04247 | | M.E. CASE NO. | | 66 04247 | |
| 1. NAME OF DECEASED (Type or Print) | | MORRIS, Constance Lee | | 2. DATE AND HOUR OF DEATH 4/21/66 6/15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE MARYLAND 21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| D. STREET ADDRESS (If rural, give location) | | 1020 N. STOCKTON STREET - 21217 | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 3/23/37 | 9. AGE (In years last birthday) 29 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME CLIFTON MORRIS | | 14. MOTHER'S MAIDEN NAME ETHEL HOLMES | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS RECORDS: BCH 4940 EASTERN AVE, BALTO. MD. 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH Pulmonary Embolism
Porphyrria | | INTERVAL BETWEEN ONSET AND DEATH 2 mos - | |
| ANTECEDENT CAUSES | | DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-5-66 19 66 to 4-21-66 19 66. | | that (I) (we) last saw the deceased alive on 4-21 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE [Signature] | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 4-21-66 | |
| 23C. PHYSICIAN'S NAME (Type) JOEL RICHMON | | 23D. ADDRESS BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE, BALTO., Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4/28/66 | | 24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery | |
| 24D. LOCATION Baltimore Md | | 25A. DATE REC'D BY HEALTH DEPT. APR 26 1966 | | 25B. NAME OF REGISTRAR R. E. Faldut | |
| 25C. FUNERAL DIRECTOR A Halstead | | 1206 W North Ave | | ADDRESS | |



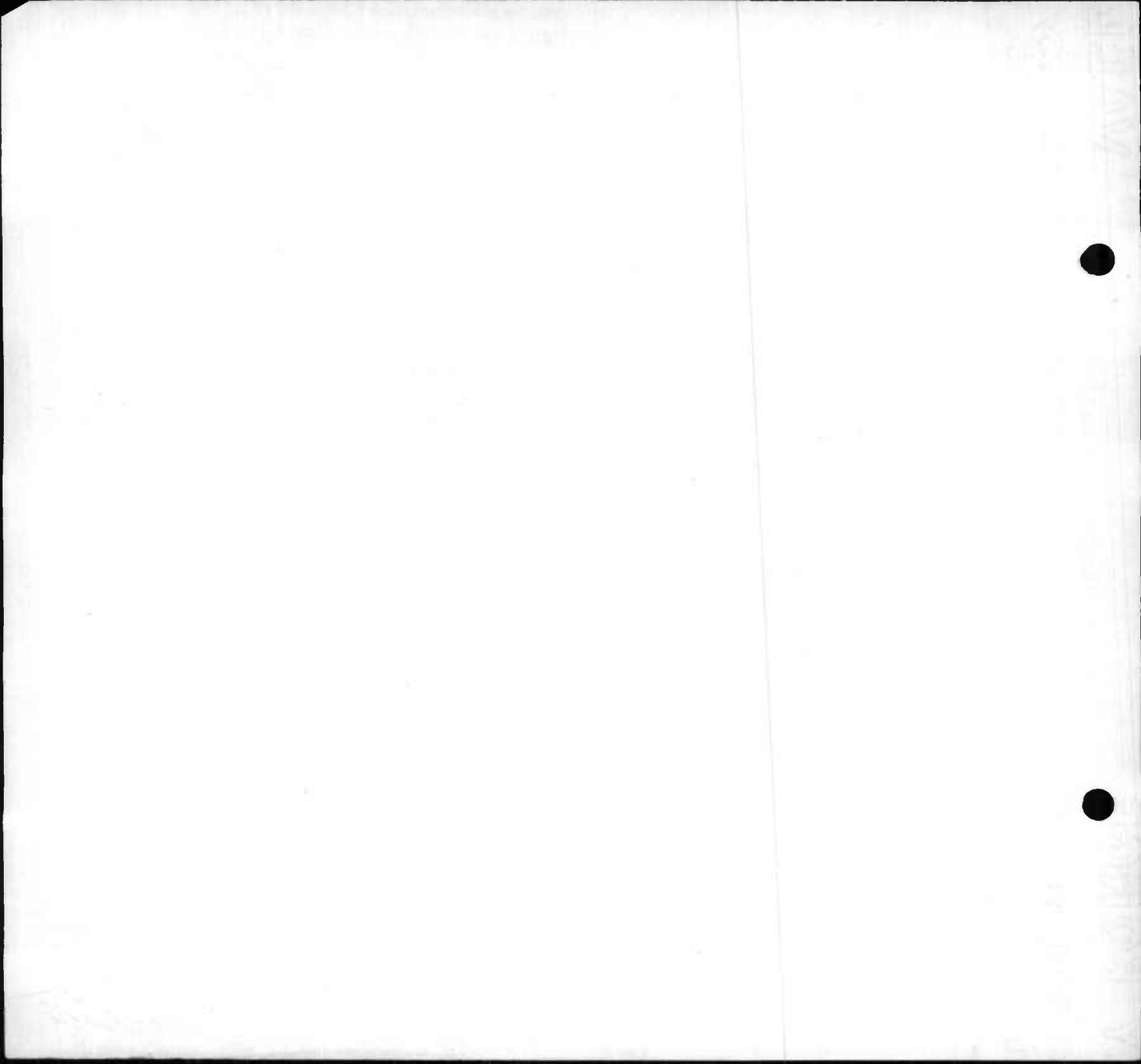
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|--|---|---|--|---|---|--|--|
| 66 04248 | | | | | 66 04248 | | | | |
| CERTIFICATE OF DEATH | | | | | Registered No. | | | | |
| BIRTH NO. 66 04248 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) LUCIA DALLA MOTTA | | | | | 2. DATE AND HOUR OF DEATH
4-23-66 5:40 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
35 Church Home & Hosp. | | | | | A. STATE Maryland B. COUNTY 6-02 | | | | |
| | | | | | C. CITY OR TOWN Baltimore (If outside city limits, write RURAL and give township) | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
2414 E. Baltimore St. | | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | | 8. DATE OF BIRTH
6-10-92 | 9. AGE (In years last birthday)
73 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME
Gregorio Bosich | | | | 14. MOTHER'S MAIDEN NAME
Anna ? | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
MRS. F. BORZYKOWSKI 13 N. POOT ST. | | | |
| 18. 260X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) central nervous system
DUE TO accident, thrombosis
(B) arteriosclerotic cardio-vascular disease
DUE TO years
(C) diabetes mellitus
years | | | | | INTERVAL BETWEEN ONSET AND DEATH
days | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED
White At <input type="checkbox"/> Work Not White <input type="checkbox"/> At Work | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-8 19 66 to 4-23 19 66 , that (I) (we) last saw the deceased alive on 4-23 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
José S. Maisog (M.D.) | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4-23-66 | |
| 23C. PHYSICIAN'S NAME (Type)
José S. Maisog | | | | | | 23D. ADDRESS
Church Home & Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/27/66 | | 24C. NAME OF CEMETERY or CREMATORY
Holy Redeemer Cem. | | | 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1966 | | | 25B. NAME OF REGISTRAR
Robert E. Farley | | | 25C. FUNERAL DIRECTOR ADDRESS
B. DABROWSKI 2818 E. BALTIMORE ST. | | | |

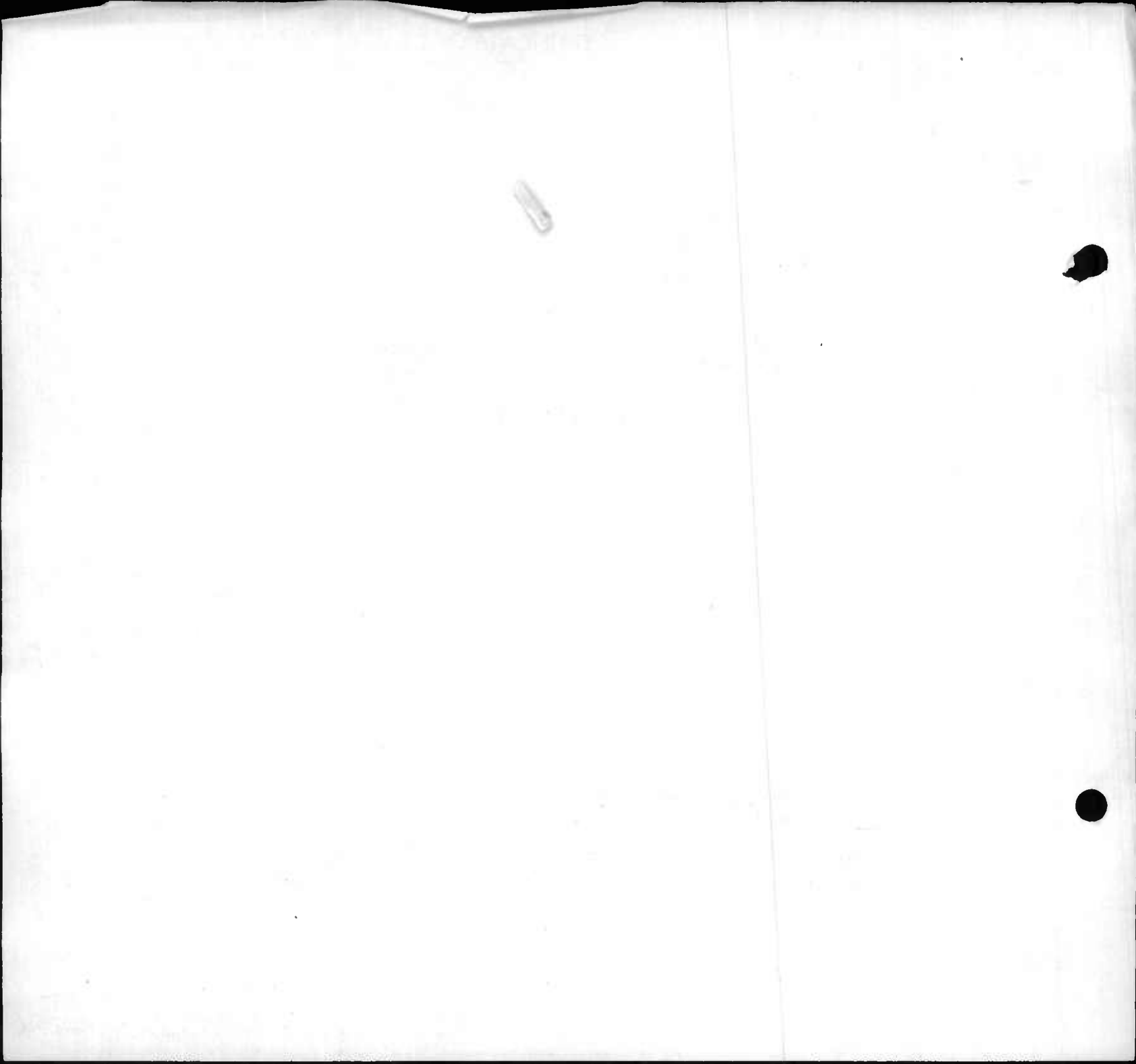
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REGISTERED No. <u>66 04249</u> | |
|--|------------------|--|---------------------------------------|--|--|
| BIRTH NO. <u>66 04249</u> | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) <u>Mildred V. Seney</u> | | 2. DATE AND HOUR OF DEATH
<u>April 24/66</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Md</u> B. COUNTY <u>14-01</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Long Green Nursing Home</u>
<u>1115 Melrose Ave</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Balto.</u> | | | |
| D. STREET ADDRESS (If rural, give location)
<u>1408 Park Ave</u> | | | | | |
| 5. SEX <u>7</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Widow</u> | 8. DATE OF BIRTH
<u>Dec. 16/93</u> | 9. AGE (In years last birthday) <u>72</u> | 10. Under 1 Yr. Months: Days Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>A.W.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Md</u> | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | |
| 13. FATHER'S NAME
<u>Ralph Moog</u> | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>J. Marion Seney Jr. (Son)</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
<u>350 X I</u>
<u>Parkinson's Disease</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
<u>1-2 years</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | (C) DUE TO | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>July 14</u> 19 <u>65</u> to <u>April 24</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>April 23</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Newland Edward Day</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>April 25, 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
M.D. <u>4-E-33rd St Baltimore 18 Maryland</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/26/66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Lorraine Park</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Balto. 7. Md</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 26 1966</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Farley, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>W. H. F. 4101 Edmondson</u> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04250 | |
|---|--|--|--|---|--|
| BIRTH NO. 66 04250 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Leland H. Spencer | | 2. DATE AND HOUR OF DEATH 4/24/66 - 9.05 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Maryland Baltimore | | 5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00 | | D. STREET ADDRESS (If rural, give location) 2165 Lorraine Ave. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY Sealtest Dairy | | 11. BIRTHPLACE (State or foreign country) New York | |
| 13. FATHER'S NAME Harvey Spencer | | 14. MOTHER'S MAIDEN NAME Rebecca Ball, Nellie | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give word or dates of service) | | 16. SOCIAL SECURITY NO. 215-01-9421 | | 17. INFORMANT Hospital Records - ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) DUE TO Libar pneumonia & abscesses LLL ? | | INTERVAL BETWEEN ONSET AND DEATH ? | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | (B) DUE TO Bronchogenic carcinoma LLL yes? | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Congestive heart failure | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April-16-1966 to April-24-1966, that (I) (we) last saw the deceased alive on April-24-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Octavio A. Ruiz | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 4/24/66 | |
| 23C. PHYSICIAN'S NAME (Type) Octavio A. Ruiz | | M.D. 23D. ADDRESS Bon Secours Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4/28/66 | | 24C. NAME OF CEMETERY OR CREMATORY Lorraine Plk Balto. Md | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. APR 26 1966 | | 25B. NAME OF REGISTRAR E. J. Fisher | |
| 25C. FUNERAL DIRECTOR Witzke F.W. 4101 Edmondson | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--------------------------|--|-------------------------------------|---|---|
| BIRTH NO. 66 04251 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 66 04251 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) FEEHRER, SAMUEL KENNETH | | | |
| 2. DATE AND HOUR OF DEATH
APRIL 24, 1966 7 ³⁰ P. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 26-01 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
UNION MEMORIAL HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location)
5930 CEDONIA AVENUE | | | |
| 5. SEX M | 6. RACE CAUCASIAN | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) D | 8. DATE OF BIRTH
11/19/23 | 9. AGE (In years last birthday)
42 | 10. Under 1 Yr. Months Days ; If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Collector | | 10B. KIND OF BUSINESS OR INDUSTRY
? | | 11. BIRTHPLACE (State or foreign country)
PENNSYLVANIA | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 13. FATHER'S NAME
CHARLES R. FEEHRER | | 14. MOTHER'S MAIDEN NAME
RUTH I. Lyvers | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
? Yes | | 16. SOCIAL SECURITY NO.
194-16-0295 | | 17. INFORMANT ADDRESS
Mrs. Emily Feehrer 5813 Daybreak Terrace | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
581-1 I
Broncho pneumonia
Hepatic Coma
Haemorrhagic Cerebration | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
ful | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/13 19 66 to 4/24 19 66 , that (I) (we) last saw the deceased alive on 4/24 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Charles E. Boring Jr. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
April 24, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
CHARLES E. BORING JR., M.D. | | 23D. ADDRESS
THE UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/27/66. | | 24C. NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cemetery | |
| | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1966 | | 25B. NAME OF REGISTRAR
Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
Leonard J. Ruck Inc. Balto. Md. 21214 | |

CHARLES F. FEEHER
 1000 N. GARDEN ST.
 PHILADELPHIA, PA.
 1910
 CHARTERED
 1000 N. GARDEN ST.
 PHILADELPHIA, PA.
 1910

100

1000 N. GARDEN ST.
 PHILADELPHIA, PA.
 1910
 CHARTERED
 1000 N. GARDEN ST.
 PHILADELPHIA, PA.
 1910

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

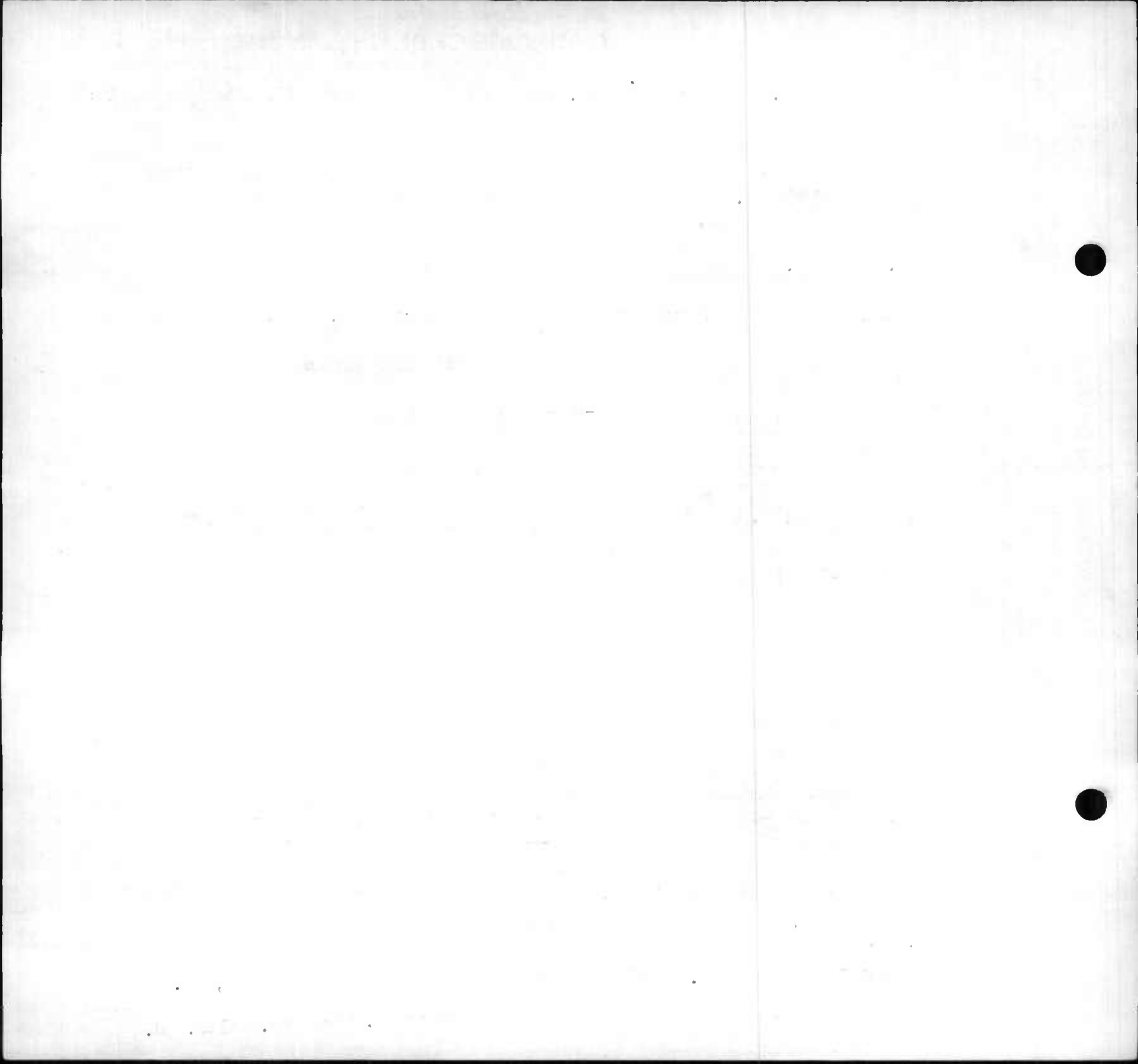
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04252 | |
|--|--|---|--|---|--|
| 66 04252 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) Thomas P. Mc Nicholas, sr. | | 2. DATE AND HOUR OF DEATH
April 24 '66 9:45 pm | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
49 North Charles Grn. Hosp.
2727 N. Charles St. City-21218 | | A. STATE Maryland
B. COUNTY Baltimore City md - 21212 | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married X2 | |
| 8. DATE OF BIRTH 2/8/86 | | 9. AGE (In years last birthday) 80 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | |
| 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? USA | | 10B. KIND OF BUSINESS OR INDUSTRY Beth Steel | |
| 13. FATHER'S NAME Patrick Mc Nicholas | | 14. MOTHER'S MAIDEN NAME Julia Hurst | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. ?? | | 17. INFORMANT Mrs. Mary S. McNicholas | | ADDRESS (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
2041 I
Acute Myeloid Leukemia | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) Sepsis probable Septicemia 2-3 days
Cerebral, posterior neck 1 week
Bronchopneumonia, bib. 2 days | | INTERVAL BETWEEN ONSET AND DEATH
2-3 days | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from April 19 1966 to April 24 1966, that (I) (we) last saw the deceased alive on April 24 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Leonard H. Fickson | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Apr. 24 '66 | |
| 23C. PHYSICIAN'S NAME (Type) Leonard H. Fickson | | 23D. ADDRESS M.D. 2702 N. Charles St. City-21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4/28/66 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 26 1966 | | 25B. NAME OF REGISTRAR A. D. E. Farley | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214 | |
| ADDRESS | | | | | |

John Smith
Baltimore
Md.

Received of
John Smith

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04253 | |
|---|--|---|--|--|--|
| 66 04253 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | |
| | | | | SCHILF, Mrs. Josephine (Mrs. Gustof) | |
| 2. DATE AND HOUR OF DEATH | | April 25, 1966 10:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| JENKINS MEMORIAL HOSPITAL
1000 S. Caton Avenue
Baltimore, Maryland 21229 | | 4315 Willshire Avenue
Baltimore, Maryland 21206 | | | |
| 5. SEX F. W. | | 6. RACE W. | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | |
| 8. DATE OF BIRTH
2/25/1893 | | 9. AGE (In years last birthday)
73 | | 10. CITIZEN OF WHAT COUNTRY
U S A | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Dressmaker | | 10B. KIND OF BUSINESS OR INDUSTRY
Merchandising | | 11. BIRTHPLACE (State or foreign country)
Princeton, Wis. | |
| 12. FATHER'S NAME
Fred Hunt | | 13. MOTHER'S MAIDEN NAME
Pauline Monte | | | |
| 14. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 15. SOCIAL SECURITY NO.
212-07-4891 | | 16. INFORMANT
MEDICAL RECORDS ROOM | |
| 17. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Septicemia | | 18. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
cachexia, ?etiology | | 19. INTERVAL BETWEEN ONSET AND DEATH
1 day | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 21A. DATE OF OPERATION | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21C. AUTOPSY? (Yes or No) | |
| | | | | | |
| 22A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 23D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 23E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 23F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 24. I certify that (H) (this hospital) attended the deceased from 4/21/1966 to 4/25/1966, that (H) (we) last saw the deceased alive on 4/25/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | |
| 25A. SIGNATURE
J. Raymond Gladue M.D. | | | | 25B. DATE SIGNED
4/25/66 | |
| 25C. PHYSICIAN'S NAME (Type)
J. Raymond Gladue, M.D. | | | | 25D. ADDRESS
Jenkins Memorial Hospital - 21229 | |
| 26A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 26B. DATE
4/28/66 | | 26C. NAME OF CEMETERY or CREMATORY
Holy Redeemer Cemetery | |
| 26D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | 26E. DATE REC'D BY HEALTH DEPT.
Apr 26 1966 | | | |
| 26F. NAME OF REGISTRAR
R. E. Farber | | 26G. FUNERAL DIRECTOR
Leonard J. Ruck Inc. Balto. Md. | | | |
| 26H. ADDRESS
21214 | | | | | |

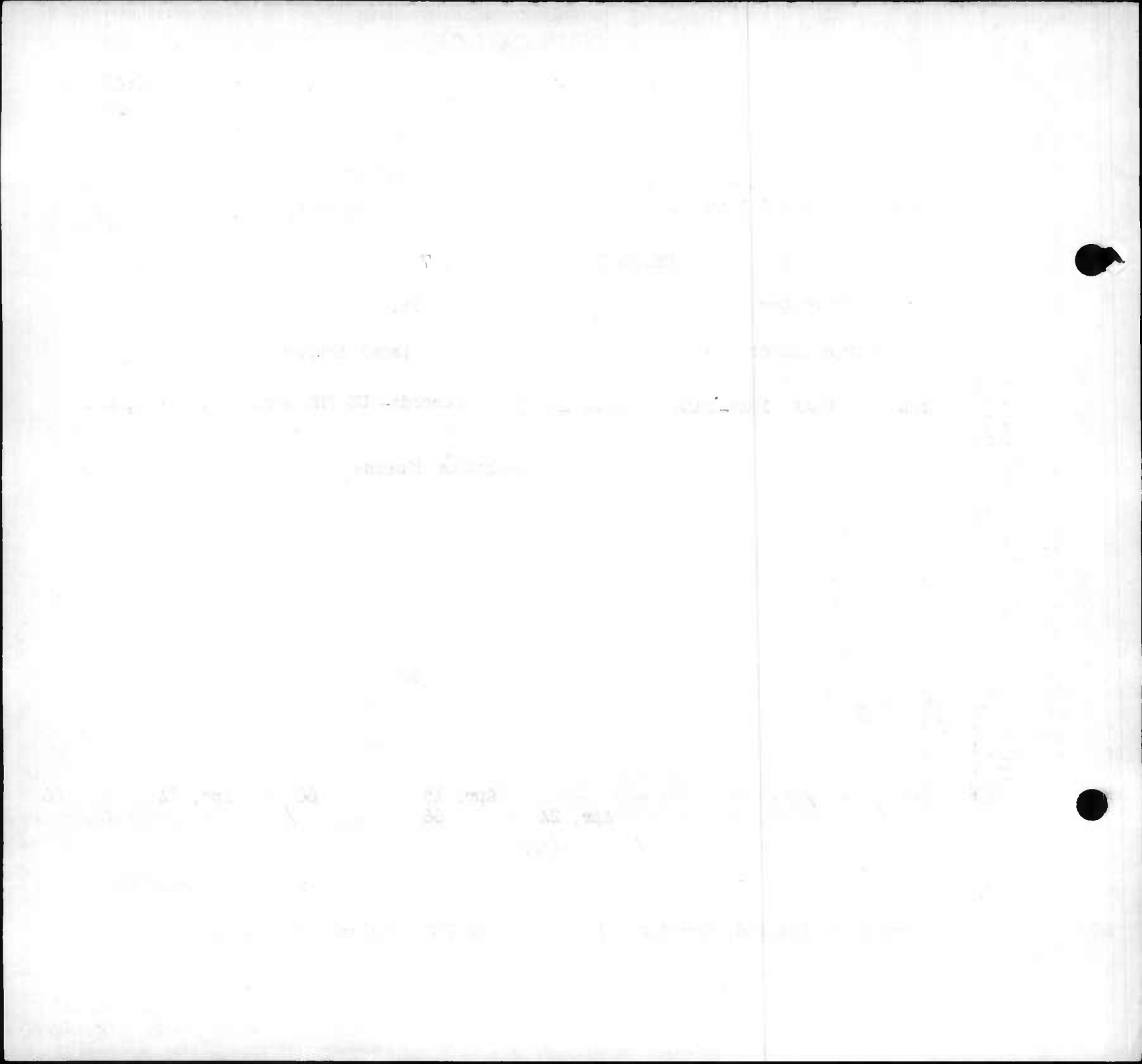


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

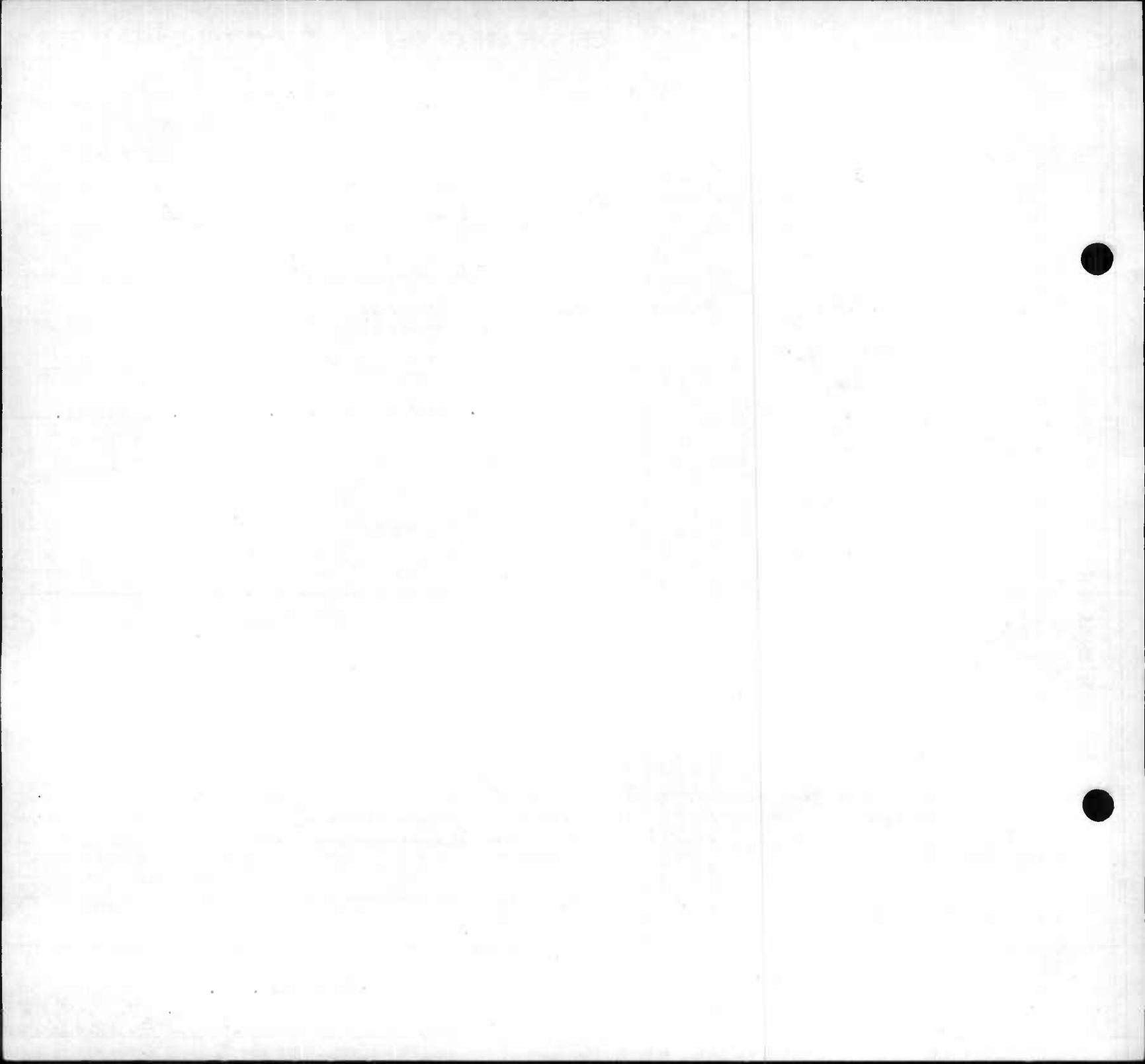
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------|--|--|------------------------------------|--|--|--|--|---------------------------------|
| 66 04254 | | | | | CERTIFICATE OF DEATH | | | | |
| BIRTH NO. | | | | | Registered No. 66 04254 | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| William Forest Stover | | | | | April 24, 1966 10:45 P M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | A. STATE B. COUNTY | | | | |
| US Public Health Service Hospital
Wyman Pk. Drive & 31st St. | | | | | Pa. V-35 | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | D. STREET ADDRESS (If rural, give location) | | | | |
| Flemington | | | | | 748 Sturdevant St. | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | 10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF
WHAT COUNTRY? |
| M | W | Married | 7/2/27 | 38 | Pipefitter helper | | Pa. | | USA |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | |
| George Stover | | | | | Hazel Kramer | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| Yes USAF 1945-1946 | | | | | 203-20-0928 | | Records- US PHS Hospital, Balto, Md. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | CAUSE OF DEATH | | | | |
| (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | | | | (A) DUE TO | | | | |
| Hodgkins' disease | | | | | 5 yrs. | | | | |
| 19. ANTECEDENT CAUSES | | | | | (B) DUE TO | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (C) DUE TO | | | | |
| II | | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| O | | | | | no | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from Apr. 15 1966 to Apr. 24 1966, that (1) (we) last saw the deceased alive on Apr. 24 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | | 23B. DATE SIGNED | | | | |
| Morton L. Axelrod | | | | | 4/25/66 | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS | | | | |
| Morton R. Axelrod, Surgeon (R) | | | | | US PHS Hospital, Balto, Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | |
| Removal | | | 4/25/1966 | | Rest Haven Cemetery | | Loch Haven, Pennsylvania | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | | | | |
| APR 26 1966 | | | Robert E. Fisher | | Wm. J. Fisher 400 North 1st Ave. Balto, Md. 17 | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

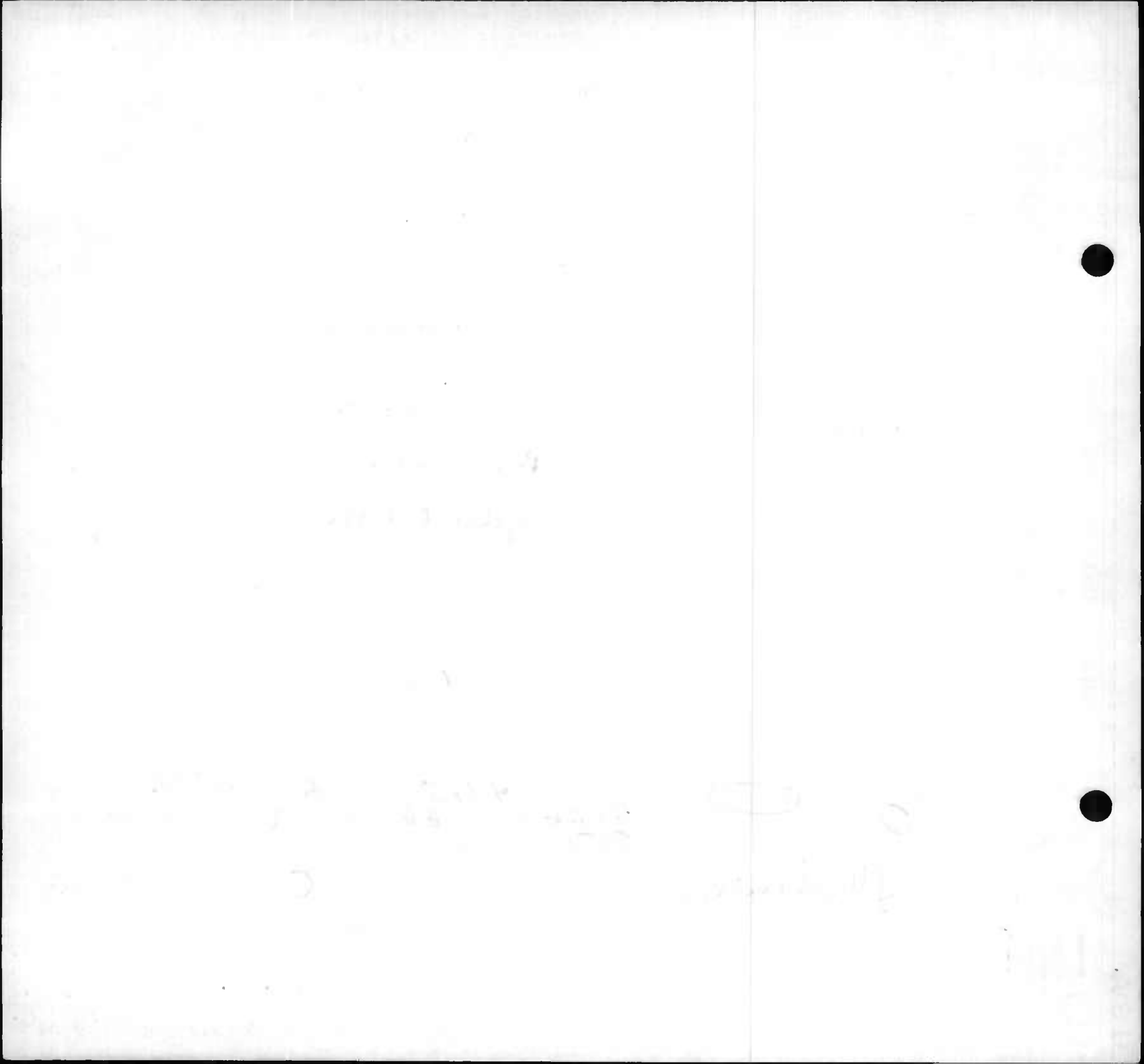
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04255 | |
|--|------------------|---|---|--|---|
| BIRTH NO.
66 04255 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Bernard Ulman | | April 25, 1966 9 ²⁵ A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
3613 Springdale Avenue
Baltimore, Maryland 21216 | | | A. STATE
Maryland
B. COUNTY
15-38 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location)
3613 Springdale Avenue 16 | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
10/26/1882 | 9. AGE (In years last birthday)
83 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
President |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME
Isaac Ulman | | | 14. MOTHER'S MAIDEN NAME
Lena Long | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No None | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS
Mr. Bernard Ulman, Jr. 415 E. Oliver St. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
331X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
Cerebral Hemorrhage
INTERVAL BETWEEN ONSET AND DEATH
few hours
Cerebral Arteriosclerosis
Years | | | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1962 to APRIL 1966, that (I) (we) last saw the deceased alive on 13 April 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Stuart H. Brager | | | | 23B. DATE SIGNED
4/25/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/27/1966 | | 24C. NAME OF CEMETERY or CREMATORY
Druid Ridge Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Pikesville, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1966 | | | |
| 25B. NAME OF REGISTRAR
E. J. ... | | 25C. FUNERAL DIRECTOR
Wm. J. ... | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|--|--|------------------------------------|---|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 66 04256 | | | | |
| BIRTH NO. 59-248366 04256 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>McAVOY, ROSE Ann</u> | | | | | 2. DATE AND HOUR OF DEATH
<u>4/26/66</u> <u>5:00</u> A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
<u>THE JOHNS HOPKINS HOSPITAL</u> | | | | | A. STATE
<u>MARYLAND</u> | | | | |
| | | | | | B. COUNTY
<u>6-04</u> | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
<u>106 N. WASHINGTON STREET</u> | | | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>NEVER MARRIED</u> | | 8. DATE OF BIRTH
<u>8-27-59</u> | 9. AGE (In years last birthday)
<u>6</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Student</u> | | 11. BIRTHPLACE (State or foreign country) | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Student</u> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | | | | | |
| 13. FATHER'S NAME
<u>JURL MCAVOY</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>BETTY VANCE</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | | | 16. SOCIAL SECURITY NO. | | | | |
| 17. INFORMANT
<u>Hospital Records</u> | | | | | ADDRESS | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>Pneumonia</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 weeks</u> | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Cystic Fibrosis</u> | | | | | congenital | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| 20A. AUTOPSY? (Yes or No)
<u>NO</u> | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED | | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/1/66</u> 19 <u>66</u> to <u>4/26</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/26</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<u>J. Winkelstein</u> | | | | | 23B. DATE SIGNED
<u>4/26/66</u> | | | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>JERRY WINKELSTEIN</u> | | | | | 23D. ADDRESS
<u>THE JOHNS HOPKINS HOSPITAL</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Removal</u> | | | | | 24B. DATE
<u>4/26/1966</u> | | | | |
| 24C. NAME OF CEMETERY or CREMATORY
<u>Family Cemetery</u> | | | | | 24D. LOCATION (City, town, or county) (State)
<u>Onego, W. Va.</u> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 26 1966</u> | | | | | 25B. NAME OF REGISTRAR
<u>Robert E. Farley</u> | | | | |
| 25C. FUNERAL DIRECTOR
<u>Wm. J. Fickner & Sons</u> | | | | | ADDRESS
<u>Baltimore, Md. 17</u> | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

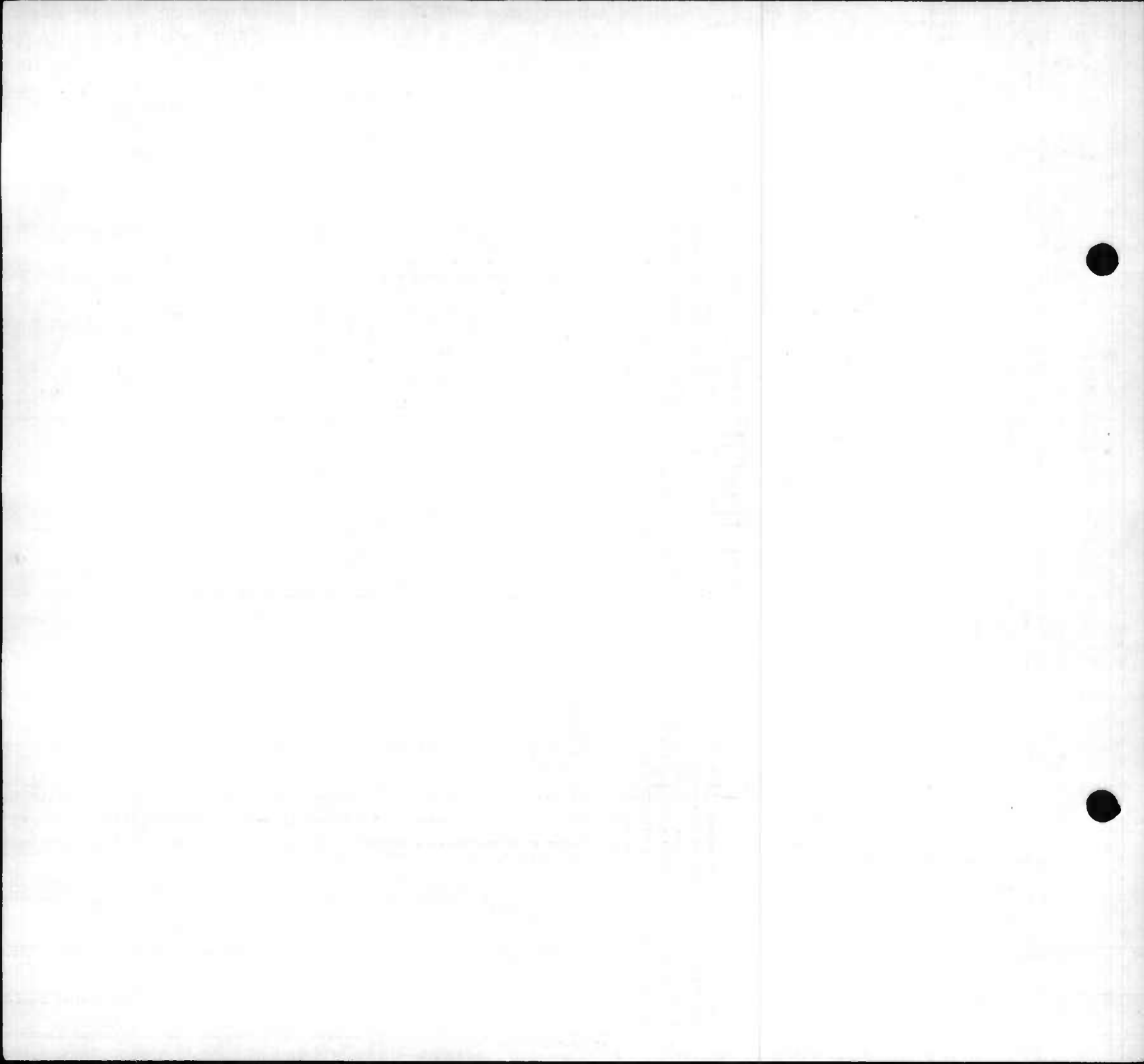
for the first time

[illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04258 | |
|--|------------------|--|-----------------------------------|--|--|
| BIRTH NO.
66 04258 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | William A. Getterman | | April 23, 1966 9:50 P.M. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE
Maryland | | B. COUNTY
21-07 | |
| Gould Convalesarium | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) | | 2713 Berwick Ave. | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
Nov. 11, 1869 | 9. AGE (in years last birthday)
96 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Painter-ret. | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Louis A. Getterman | | 14. MOTHER'S MAIDEN NAME
Marie E. Gerhold | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
John Getterman 6155 Dunroming Road | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
156.1 I
HEPATIC CARCINOMA | | CAUSE OF DEATH
(A) DUE TO
Hepatic Carcinoma | | INTERVAL BETWEEN ONSET AND DEATH
? | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO
Generalized Arteriosclerosis | | 23 yrs. | |
| (C) _____ | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-1-1923 to 4-22-1966, that (I) (we) last saw the deceased alive on 4-22-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Milton C. Lang | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4-25-66 | |
| 23C. PHYSICIAN'S NAME (Type)
Milton C. Lang | | 23D. ADDRESS
M.D. 2117 Belair Road | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4.27/66 | | 24C. NAME OF CEMETERY or CREMATORY
Lorraine Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Woodlawn, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1966 | | 25B. NAME OF REGISTRAR
R. E. Farber | | 25C. FUNERAL DIRECTOR ADDRESS
Ullrich Funeral Home 4210 Belair Road | |



Body released to UMH for post-mortem ex.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|----------|--|--|--|-------------------------|--|
| G-656 | | 66 04259 | | CITY OF BALTIMORE HEALTH DEPARTMENT | | Registered No. 66 04259 | |
| BIRTH NO. | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| Garner; Elsie Grupp | | | | April 23, 1966 5:45 p. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| Union Memorial Hospital
Baltimore, Maryland 21218 | | | | Baltimore, Maryland | | | |
| 5. SEX 6. RACE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | | | 8. DATE OF BIRTH 9. AGE (In years last birthday) | | | |
| Female Caucasian Married | | | | 7-12-86 79 | | | |
| 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 11. BIRTHPLACE (State or foreign country) | | | |
| None | | | | MARYLAND | | | |
| 13. FATHER'S NAME | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Charles Grupp | | | | U.S.A | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| None | | | | ERNEST J. GARNER PASADENA MD | | | |
| 17. INFORMANT ADDRESS | | | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | |
| ROYAL BEACH RD | | | | Pulmonary Embolus | | | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTecedent CAUSES | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Fracture of elbow, shoulder, left and pelvis | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| April 21-66 | | | | Fracture left elbow | | | |
| 20A. AUTOPSY? (Yes or No) | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| Yes | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| Yes | | | | Washington D.C. Son's home | | | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21E. HOW DID INJURY OCCUR? | | | |
| April 14, 1966 | | | | stepping & fall to floor | | | |
| 22. I certify that (A) (this hospital) attended the deceased from April 16, 1966 to April 23, 1966. | | | | | | | |
| that (B) (we) last saw the deceased alive on April 23, 1966 and that in (C) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| May Fan | | | | 4-23-66 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| DR. KANG FAN | | | | Union Memorial Hospital
Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | |
| BURIAL | | | | 4/27/66 | | | |
| 24C. NAME OF CEMETERY or CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | | | |
| OAK LAWN | | | | COLGATE MD | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | |
| APR 26 1966 | | | | R. L. E. Taylor | | | |
| 25C. FUNERAL DIRECTOR | | | | 25D. ADDRESS | | | |
| ULLRICH FUNERAL HOME | | | | 4216 BELAIR | | | |

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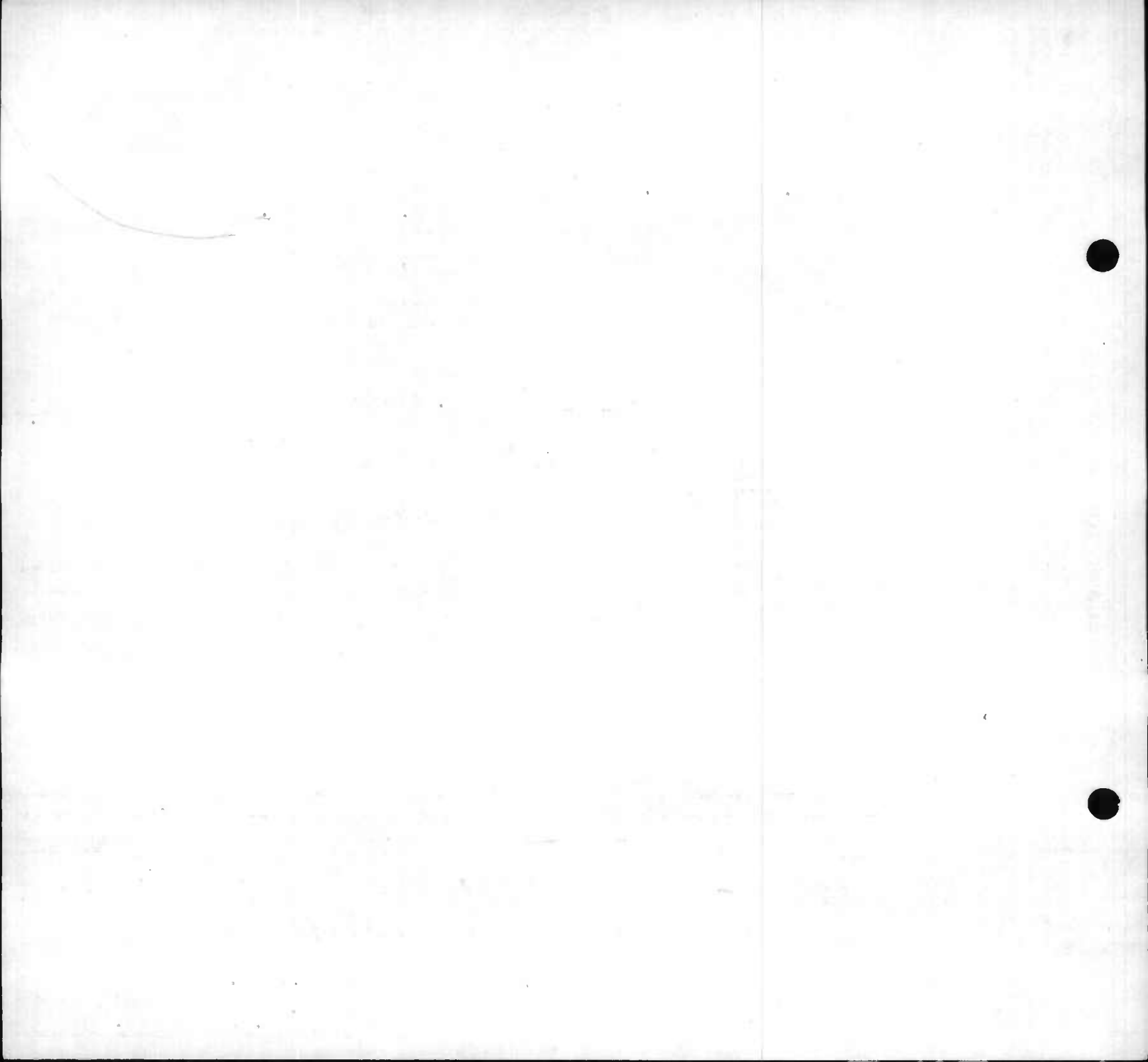
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

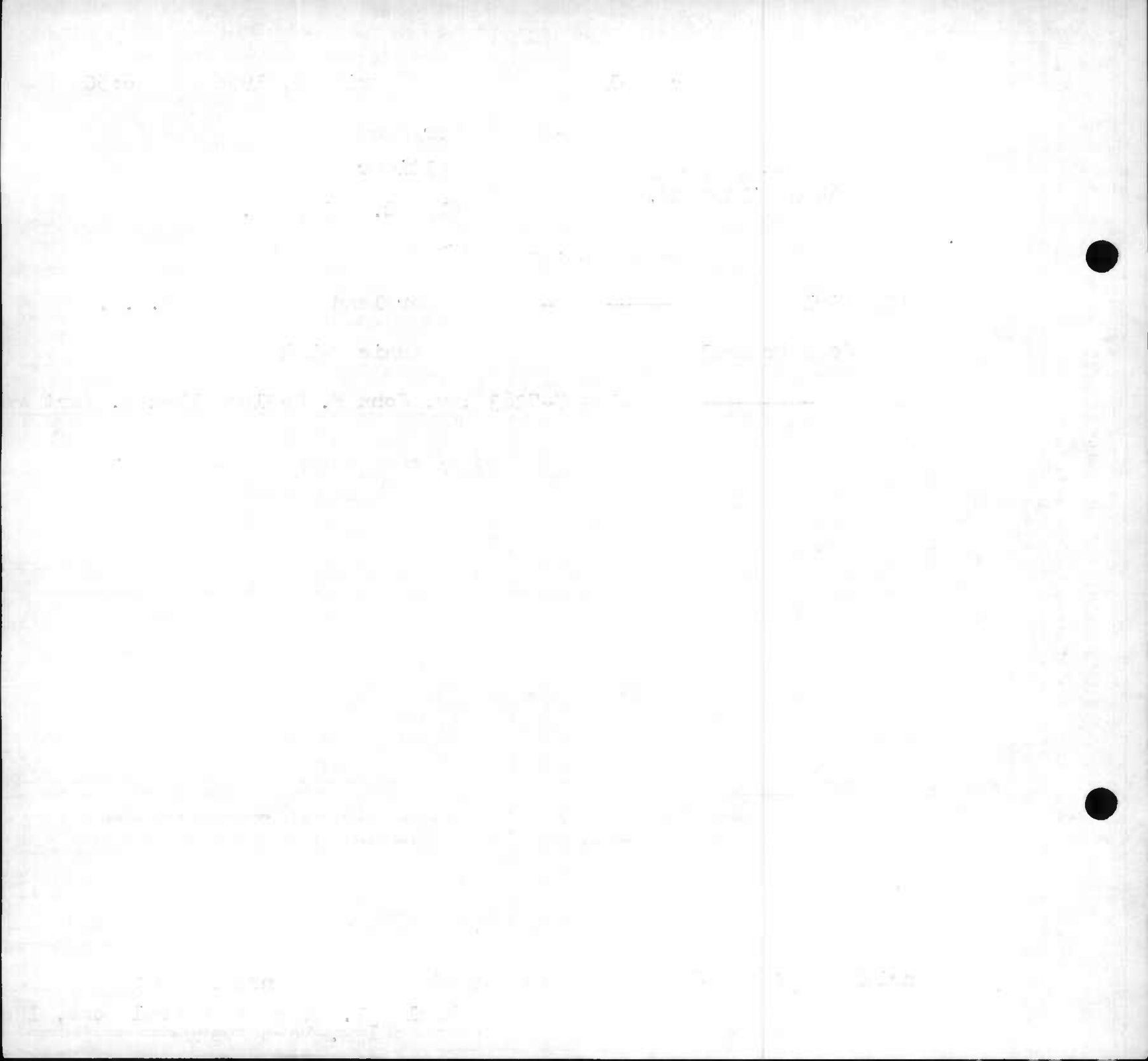
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>6604260</u> | |
|---|-------------------------|--|--|--|---|
| BIRTH NO. <u>66 04260</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Oscar Wilson</u> | | 2. DATE AND HOUR OF DEATH
<u>April 23, 1966</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY <u>9-08</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>926 E. North Ave.</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>926 E. North Ave.</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>Negro</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Widowed</u> | 8. DATE OF BIRTH
<u>June 27, 1884</u> | 9. AGE (In years last birthday)
<u>81</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Truck Driver</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | |
| 13. FATHER'S NAME
<u>Benjamin Wilson</u> | | 14. MOTHER'S MAIDEN NAME
<u>Sidney Hickinbottom</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>215-10-3649</u> | | 17. INFORMANT ADDRESS
<u>Mrs. Carolyn McCamey 2312 Allendale Rd.</u> | |
| 18. <u>420.0</u> I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) <u>Arteriosclerotic Heart Disease</u>
DUE TO | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>Arteriosclerosis</u>
DUE TO | | | |
| | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>Pylonephritis, Anemia</u> | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>October 19 65</u> to <u>April 19 66</u> , that (I) (we) last saw the deceased alive on <u>April 18 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Jesse T. Holmes</u> M.D. | | | | 23B. DATE SIGNED
<u>4/26/66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Jesse T. Holmes</u> | | 23D. ADDRESS
<u>508 E. NORTH AVE. BALTO MD.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/27/66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Arbutus Mem. Park</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State)
<u>Balto., Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 26 1966</u> | | 25B. NAME OF REGISTRAR
<u>R. E. Farkas</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>Wm C March 928 E. North Ave.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

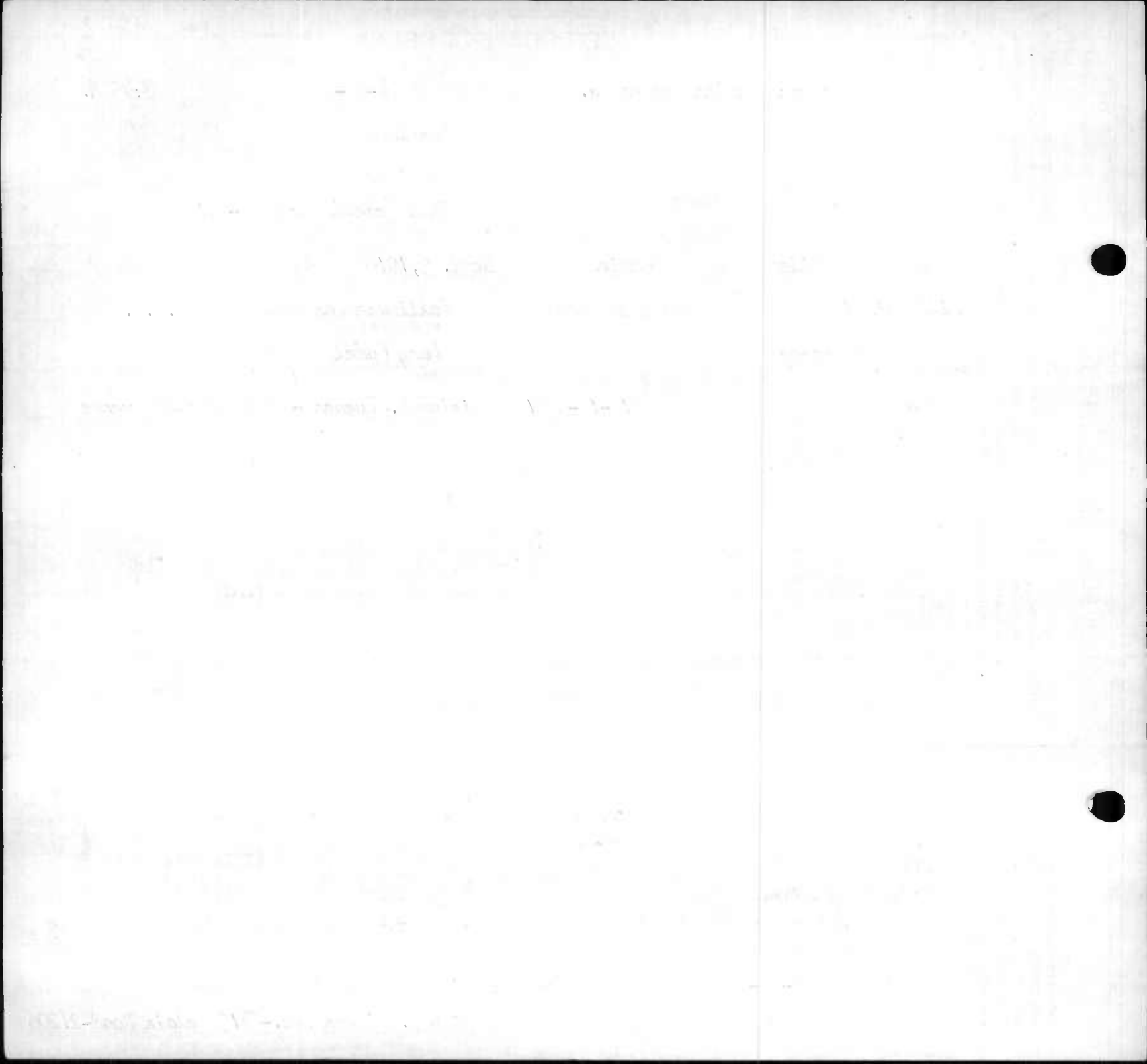
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---------|--|--|--|------------------|--|---------------------------------|--|--|--|-----------------------------|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|--|
| 66 04261 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 04261 | | | | | | | | | | | | | | | | | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | | Helen Dressel | | | | | April 24, 1966 6:50 P.M. | | | | | | | | | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | A. STATE B. COUNTY | | | | | | | | | | | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | | (If not in hospital or institution, give street address or location) | | | | | Maryland | | | | | | | | | | | | | | | | | | | |
| Ashburton House
3520 Hilton Rd. | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | Baltimore | | | | | | | | | | | | | | | | | | | |
| D. STREET ADDRESS (If rural, give location) | | | | | 519 Mt. Holly St. | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | | | | | | | | | | | | | | |
| F | | W | | Never Married | | 6/18/1898 | | 87 | | | | | | | | | | | | | | | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) | | | | | 12. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | | | | | |
| Salesgirl | | | | | ----- | | | | | Maryland | | | | | U.S.A. | | | | | | | | | | | | | | |
| 13. FATHER'S NAME | | | | | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| John Dressel | | | | | | | | | | Annie Walsh | | | | | | | | | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT ADDRESS | | | | | | | | | | | | | | | | | | | |
| No | | | | | 216-07-7383 | | | | | Rev. John F. McGlone 1532 E. Fort Av | | | | | | | | | | | | | | | | | | | |
| 18. 332 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | CAUSE OF DEATH | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| (A) Cerebral thrombosis | | | | | | | | | | 1 week | | | | | | | | | | | | | | | | | | | |
| (B) DUE TO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (C) DUE TO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ANTECEDENT CAUSES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| D | | | | | | | | | | No | | | | | | | | | | | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | | | | | | | | | | | |
| | | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | |
| 22. I certify that (I) (the hospital) attended the deceased from Dec 6 1963 to April 24 1966, that (I) (we) last saw the deceased alive on April 23 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | | | | | | 23B. DATE SIGNED | | | | | | | | | | | | | | | | | | | |
| Abraham B. Hurwitz | | | | | | | | | | April 26, 1966 | | | | | | | | | | | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | |
| ABRAHAM B. HURWITZ | | | | | 7501 Liberty Road, Baltimore, Md. | | | | | | | | | | | | | | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | | 24B. DATE | | | | | 24C. NAME OF CEMETERY or CREMATORY | | | | | 24D. LOCATION (City, town, or county) (State) | | | | | | | | | | | | | | |
| Burial | | | | | 4/27/66 | | | | | New Cathedral Cemetery | | | | | Baltimore, Maryland | | | | | | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | | 25B. NAME OF REGISTRAR | | | | | 25C. FUNERAL DIRECTOR ADDRESS | | | | | | | | | | | | | | | | | | | |
| APR 26 1966 | | | | | Charles E. J. J. | | | | | Charles L. Stevens Funeral Home, INC | | | | | 1501 E. Fort Avenue | | | | | | | | | | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|--|--|--|---|--|--|---|--|
| 66 04262 | | | | | REGISTERED NO. 66 04262 | | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Raymond Walter Turner Sr.</i> | | | | | 2. DATE AND HOUR OF DEATH
<i>4-22-66</i> <i>8:45 A.</i> M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

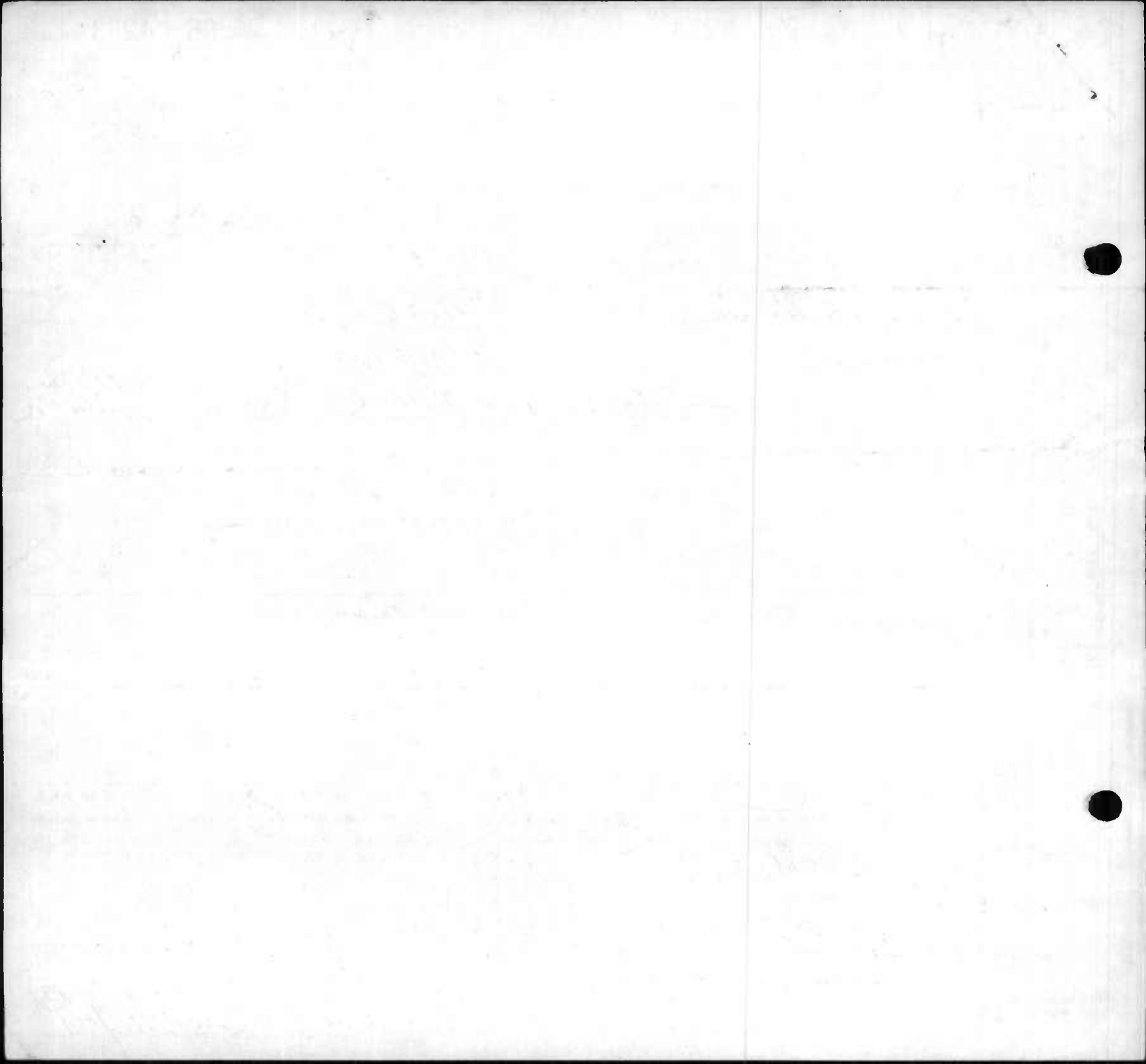
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>5502 Cedella Avenue</i> | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY <i>26-01</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i>
D. STREET ADDRESS (If rural, give location)
<i>5502 Cedella Avenue - 21206</i> | | | | |
| 5. SEX
<i>Male</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Married</i> | 8. DATE OF BIRTH
<i>Sept. 9, 1916</i> | 9. AGE (In years last birthday)
<i>49</i> | 10. Under 1 Yr. Months | 11. Under 24 Hrs. Days | 12. Under 24 Hrs. Hours | 13. Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Mill Wright</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Bethlehem Steel</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore Maryland</i> | | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>Walter Turner</i> | | | | | 14. MOTHER'S MAIDEN NAME
<i>Mary Cadel</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | 16. SOCIAL SECURITY NO.
<i>216-12-5731</i> | | 17. INFORMANT
<i>Miriam E. Turner - 5502 Cedella Avenue</i> | | | | ADDRESS |
| 18. <i>420.1</i> I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>Coronary Artery Disease</i>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>Atherosclerosis</i> | | | | | (A) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>7 yrs.</i> |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | (B) DUE TO | | | | <i>7 yrs.</i> |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>31 May 1955</i> to <i>27 April 1966</i> , that (I) (we) last saw the deceased alive on <i>24 Feb 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<i>Howard Goodman</i> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>25 April 66</i> | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Howard Goodman</i> | | | | | 23D. ADDRESS
<i>8604 Hartford Road Baltimore Md.</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | 24B. DATE
<i>4-26-66</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Dulaney Valley Memorial</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore Maryland</i> | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>APR 26 1966</i> | | | 25B. NAME OF REGISTRAR
<i>P. E. G. E. Turner</i> | | | 25C. FUNERAL DIRECTOR
<i>John C. Miller Inc. - 6415 Belair Road - 21206</i> | | | ADDRESS |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|--|---|--|--|--|------------------------------------|------------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 66 04263 | | | | |
| BIRTH NO.
66 04263 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Charles Stinchcomb</u> | | | | | 2. DATE AND HOUR OF DEATH
<u>7/19/66</u> <u>5:50 Am.</u> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>46 Lutheran Hospital</u> | | | | | A. STATE <u>Maryland</u>
B. COUNTY <u>Baltimore</u> | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore, Md.</u> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
<u>6811 - Camp Field Rd.</u> | | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>married</u> | 8. DATE OF BIRTH
<u>10/11/80</u> | 9. AGE (In years last birthday)
<u>85</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>PRODUCE DEALER</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country)
<u>BALTO MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<u>GEORGE</u> | | | 14. MOTHER'S MAIDEN NAME
<u>ANNIE WALTERS</u> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO.
<u>218-32-244A</u> | | | 17. INFORMANT
<u>Augustine Smith Home</u> | | | |
| | | | 18. <u>442X-177X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | INTERNAL BETWEEN ONSET AND DEATH | | | |
| | | | (A) <u>UREMIA</u> DUE TO | | | | | | |
| | | | (B) <u>Arteriole nephrosclerosis</u> DUE TO | | | | | | |
| | | | (C) | | | | | | |
| | | | ANTECEDENT CAUSES | | | | | | |
| | | | DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | |
| | | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | |
| | | | <u>Congestive Heart Failure</u> | | | | | | |
| | | | <u>Ca of Prostate</u> | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>April 13</u> , 19 <u>66</u> to <u>April 19</u> , 19 <u>66</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>April 19</u> , 19 <u>66</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> <u>(did not)</u> view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<u>Robert C. Blackmon</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>4/19/66</u> | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Robert C. Blackmon</u> | | | | | 23D. ADDRESS
<u>Lutheran Hospital</u> | | | | |
| 24A. BURIAL OR CREMATION REMOVED (Specify) | | 24B. DATE
<u>4/22/66</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Linden Pl</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Balto Md</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 26 1966</u> | | 25B. NAME OF REGISTRAR
<u>R. E. Farley</u> | | 25C. FUNERAL DIRECTOR
<u>W. E. E. Farley</u> | | | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

MARIO HALL

2. DATE AND HOUR PRONOUNCED DEAD

April 20, 1966 10:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2728 Prospect St.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never married

8. DATE OF BIRTH

6/30/65

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

James William Hall

14. MOTHER'S MAIDEN NAME

Imogene

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

James W. Hall 2728 Prospect St.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Bilateral otitis media
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-20-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

WALLEY FORGE

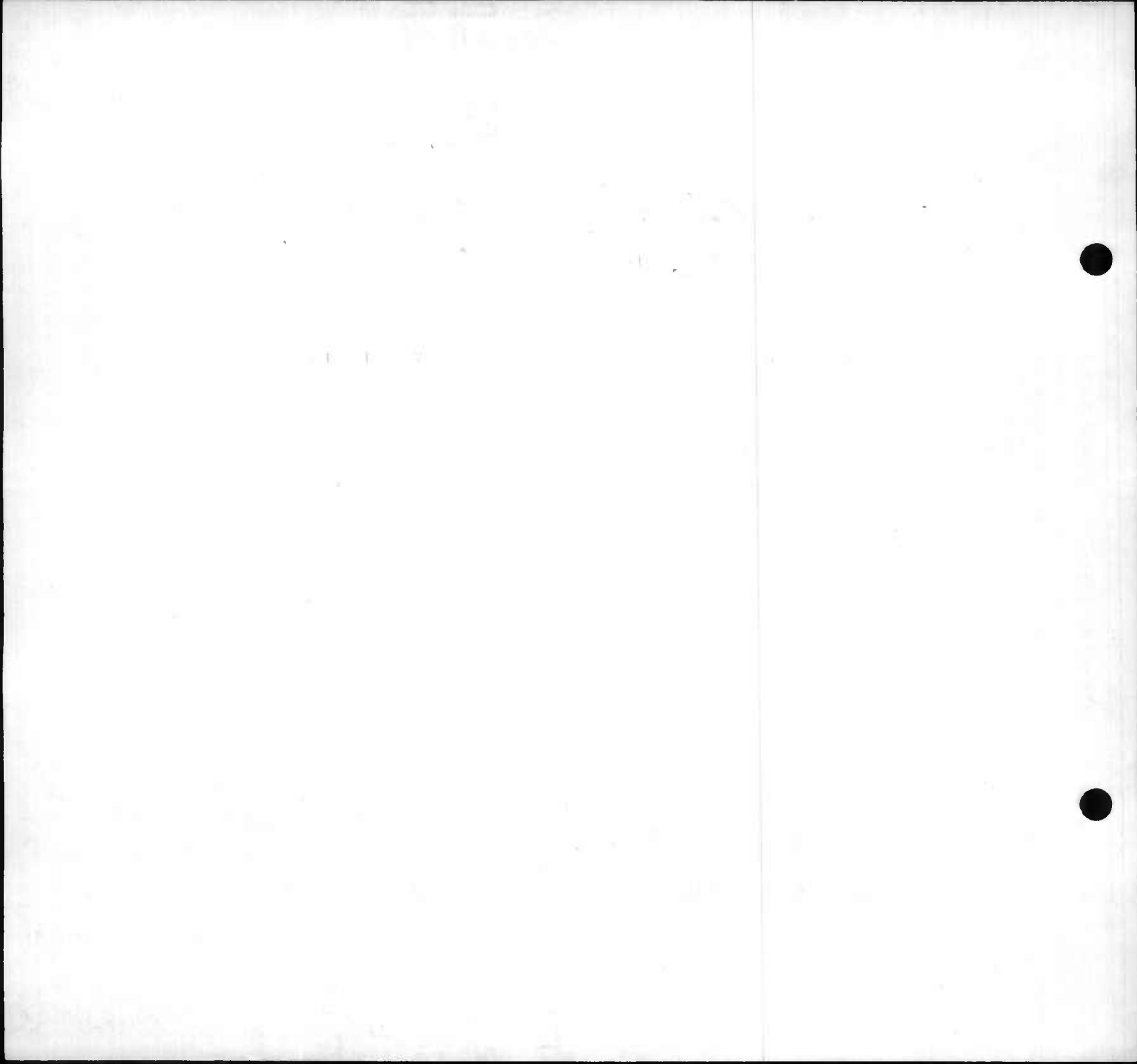
SALE CONTENT

USA

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

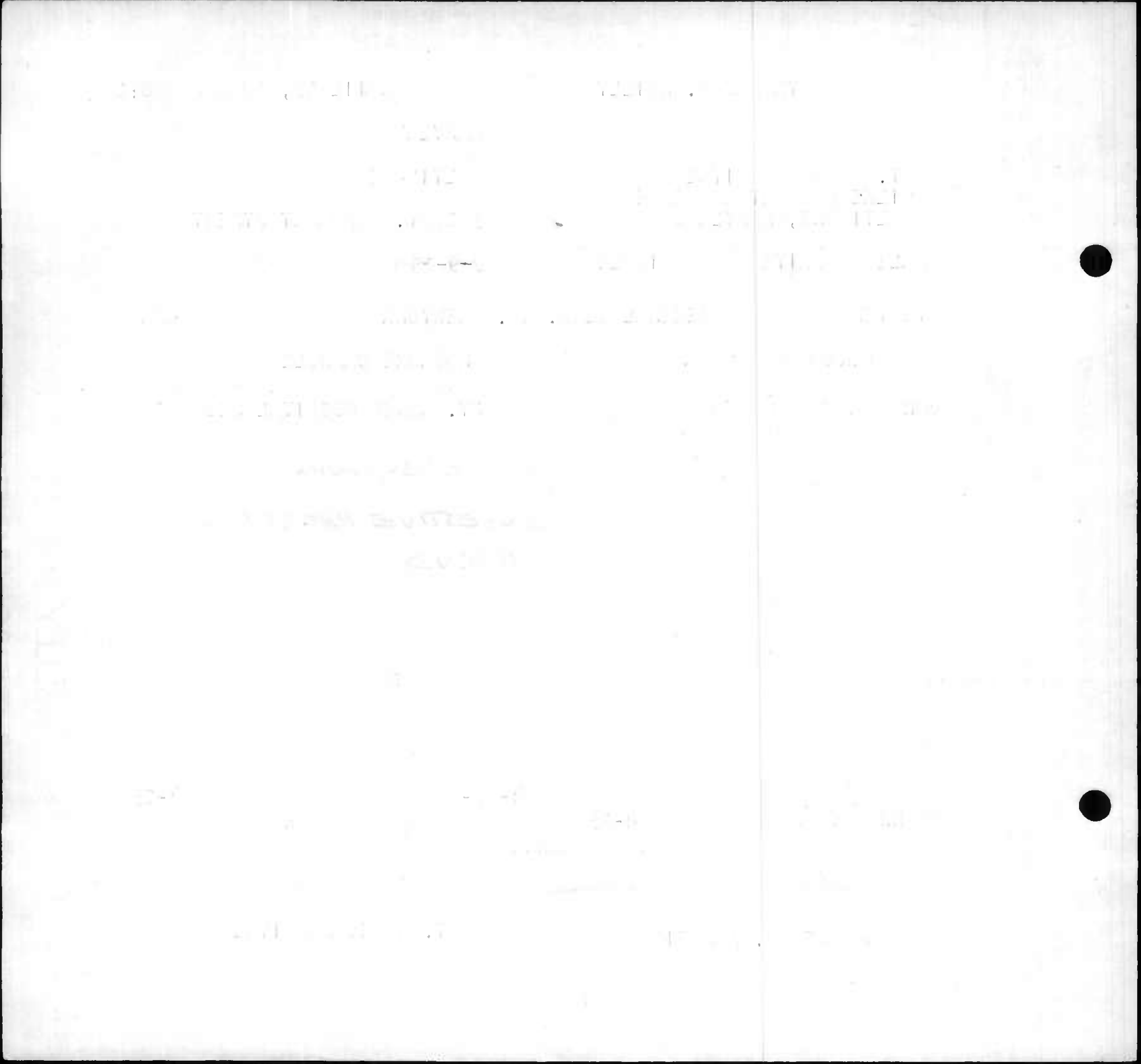
| | | | | | |
|---|---|--|---|--|--|
| BIRTH NO. 66 04285 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04285 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | DATE AND HOUR OF DEATH
4/19/66 8:40 PM | |
| 1. NAME OF DECEASED
(Type or Print) Green, Joseph | | 2. DATE AND HOUR OF DEATH | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)
A. STATE MARYLAND
B. COUNTY BALT. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hosp | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location)
746 Glenwood Ave | | | |
| 5. SEX
MALE | 6. RACE
COLORED | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
SINGLE | 8. DATE OF BIRTH
1/1/97 | 9. AGE (In years last birthday)
66 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
JOSEPH GREEN | | | |
| 14. MOTHER'S MAIDEN NAME
MARY GRIFFIN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Severe Chronic Obstructive Lung Disease | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
15 yrs | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/7 19 66 to 4/19 19 66 .
that (I) (we) last saw the deceased alive on 4/19 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
E. Eugene Page | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/19/66 | |
| 23C. PHYSICIAN'S NAME (Type)
E. Eugene Page | | 23D. ADDRESS
Johns Hopkins Hospital Baltimore MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/23/66 | | 24C. NAME OF CEMETERY or CREMATORY
Mt Auburn | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore MD | | 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1966 | | 25B. NAME OF REGISTRAR
Ruth E. Farley | |
| 25C. FUNERAL DIRECTOR
Charles A. Rice | | ADDRESS
Baltimore | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66-04286 | |
|--|-------------------------|---|--|--|---|
| BIRTH NO. 66-04286 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) THOMAS J. REILLY | | 2. DATE AND HOUR OF DEATH
APRIL 23, 1966 8:25P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
ST. AGNES HOSPITAL
WILKENS & CATON AVENUE
BALTIMORE, MARYLAND | | A. STATE MARYLAND
B. COUNTY 25-05 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location)
3721 ST. MARGARET STREET | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
SINGLE | 8. DATE OF BIRTH
9-9-15 | 9. AGE (In years last birthday)
50 | 10. Under 1 Yr. Months Days
11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
TESTER | | 10B. KIND OF BUSINESS OR INDUSTRY
GENERAL ELEC. CO. | | 11. BIRTHPLACE (State or foreign country)
NEWYORK | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 13. FATHER'S NAME
BERNARD REILLY | | | 14. MOTHER'S MAIDEN NAME
ROSANNE CARROLL | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) UNKNOWN | | 16. SOCIAL SECURITY NO.
091-09-9287 | | 17. INFORMANT ADDRESS
C. WARREN 3721 ST. MARGARET 21225 | |
| 18. YES 11-28-45 422.1 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) BRONCHOPNEUMONIA | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (B) CONGESTIVE HEART FAILURE | | | |
| ANTECEDENT CAUSES | | (C) ASCVD | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from 4-17- 19 66 to 4-23 19 66 , that (X) (we) last saw the deceased alive on 4-23 19 66 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) did (X) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Manfred F. Amrhein</i> M.D. | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
MANFRED F. AMRHEIN M.D. | | | | 23D. ADDRESS
ST. AGNES HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-27-66 | | 24C. NAME OF CEMETERY OR CREMATORY
Holy Cross Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Anne Arundel Co. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1966 | | 25B. NAME OF REGISTRAR
R. E. E. E. | | 25C. FUNERAL DIRECTOR ADDRESS
W. A. Fialkowski 2007 Eastern Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

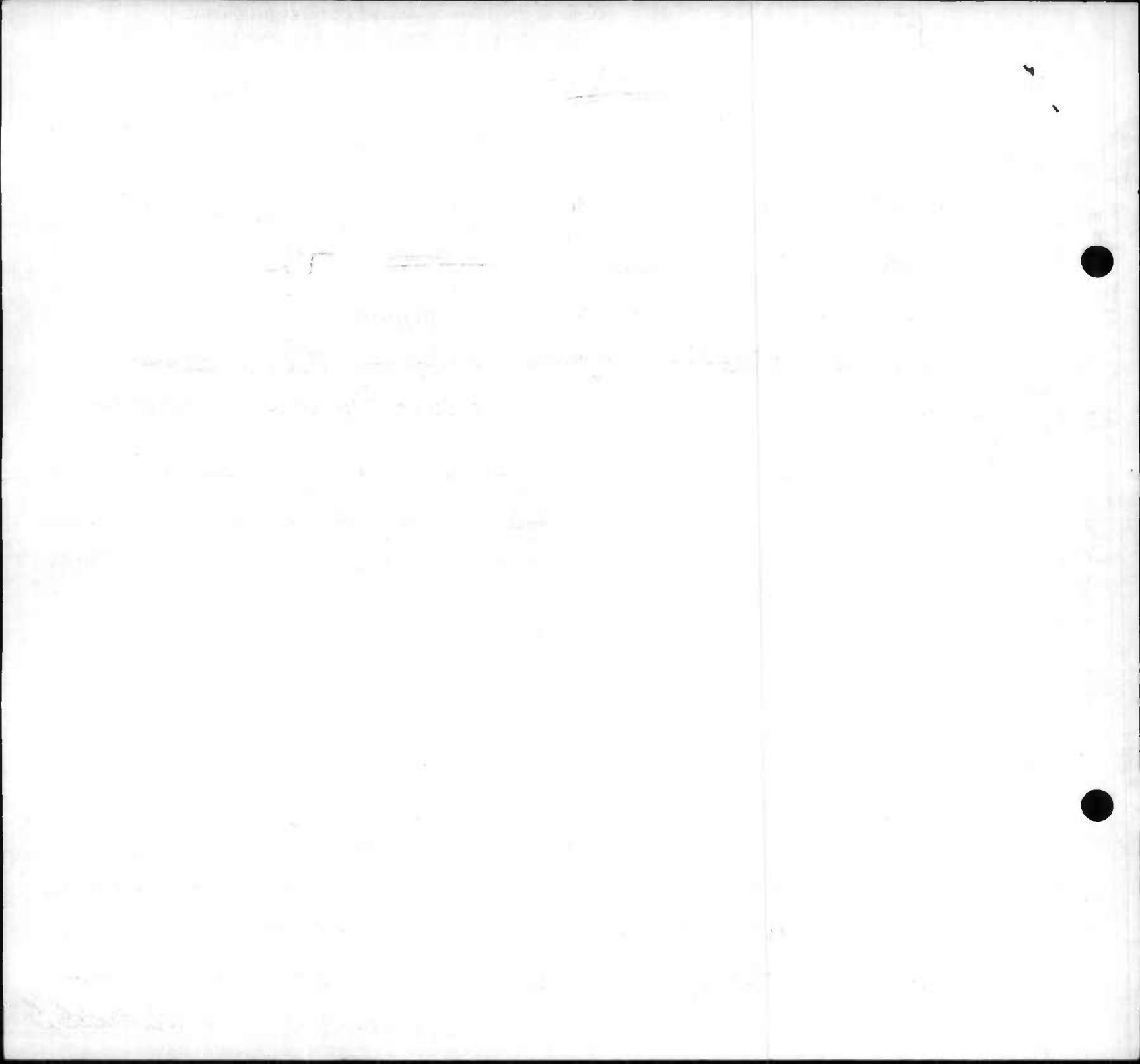
| | | | | | |
|---|--------------------------------|---|---|---|---|
| BIRTH NO. 9350
M.E. CASE NO. 66 04287 | | CERTIFICATE OF DEATH
BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04287 | |
| 1. NAME OF DECEASED
(Type or Print) <u>GODDIN, IRA DORA</u> | | | 2. DATE AND HOUR OF DEATH
<u>APRIL 23 - 1966 1 11 45 P.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>SINAI HOSPITAL f(BALTIMORE)</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE <u>MARYLAND</u> B. COUNTY <u>27-20</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>
D. STREET ADDRESS (If rural, give location) <u>3111 PARKINGTON AVE #15</u> | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>CAUCA</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>WIDOWED</u> | 8. DATE OF BIRTH
<u>7-2</u> | 9. AGE (In years last birthday)
<u>72</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>at Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>LITHUANIA</u> | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> |
| 13. FATHER'S NAME
<u>unknown Morris Snyder</u> | | | 14. MOTHER'S MAIDEN NAME
<u>unknown Reva Giss</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u> </u> | 17. INFORMANT ADDRESS
<u>Attant Goddin - home</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | CAUSE OF DEATH
(A) <u>Sepsis - source diabetic gangrene</u>
DUE TO <u>chronic hep fistula draining</u>
(B) <u>arteriosclerosis cardiovascular</u>
DUE TO <u> </u>
(C) <u>Diabetic mellitus</u> | | |
| INTERVAL BETWEEN ONSET AND DEATH
<u>48 HOURS</u>

<u>MANY YEARS</u>

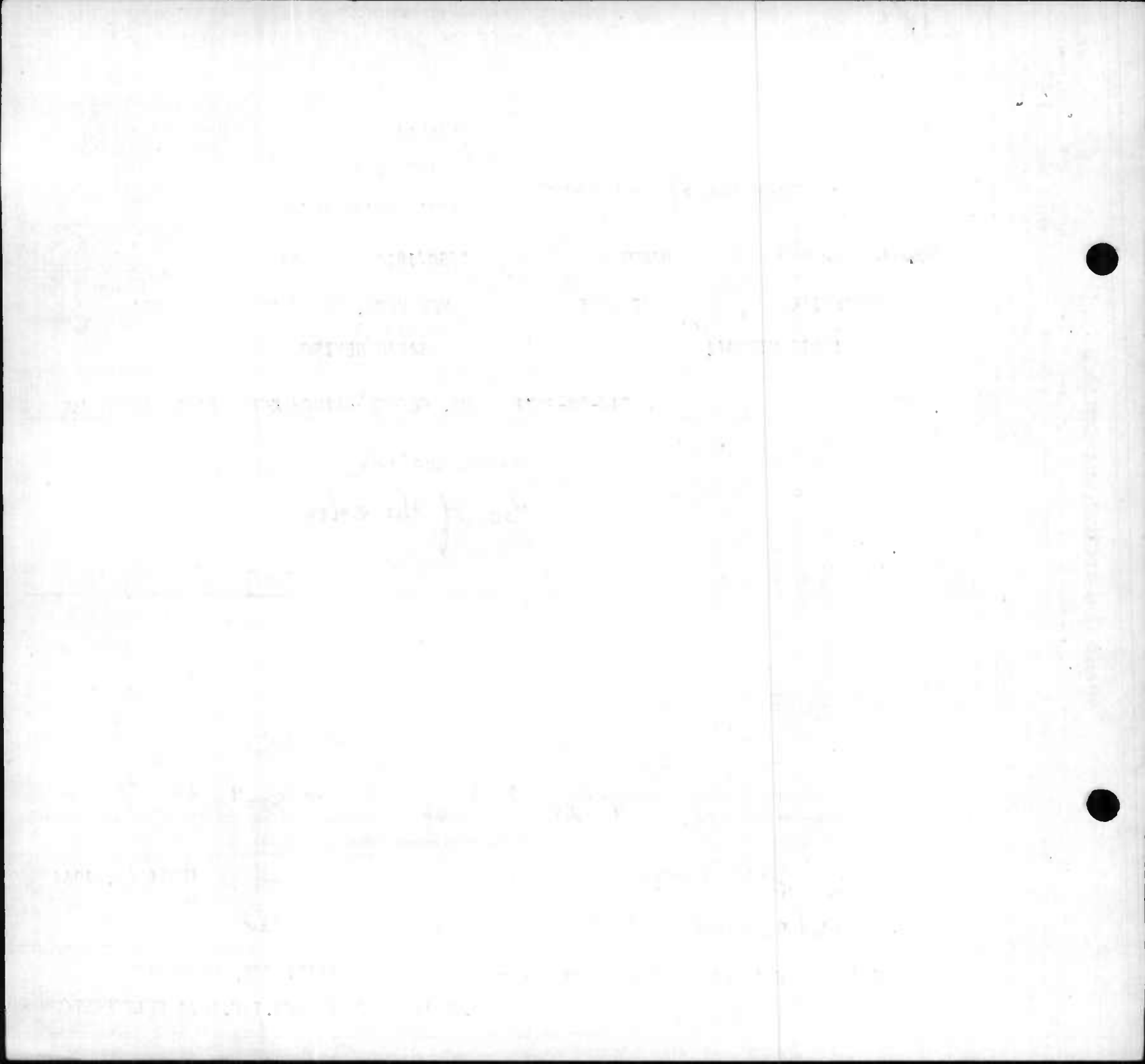
<u>MANY YEARS</u> | | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>none</u> | | |
| 19A. DATE OF OPERATION
<u> </u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u> </u> | | 20A. AUTOPSY? (Yes or No) <u> </u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u> </u> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u> </u> | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u> </u> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<u> </u> | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>APRIL 23 1966</u> to <u>APRIL 23 1966</u>, that (I) (we) last saw the deceased alive on <u>APRIL 23 1966</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Michael Levin</u> M.D. | | | | 23B. DATE SIGNED
<u>APRIL 23, '66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>MICHAEL LEVIN</u> M.D. | | | | 23D. ADDRESS
<u>SINAI HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>4/24/66</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Lubawitz Muncie</u> | |
| 24D. LOCATION (City, town, or county) <u>Baltimore Md.</u> | | 24E. LOCATION (City, town, or county) <u>Baltimore Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 27 1966</u> | | 25B. NAME OF REGISTRAR
<u>R. E. Farkas</u> | | 25C. FUNERAL DIRECTOR
<u>Sal Levinson & Bros. 6010 Reisterstown Rd.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>66 04268</u> | |
|---|-------------------------|---|--|---|--|---|--|
| BIRTH NO. <u>B 452 66 04268</u> | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>BLINCHIKOFF, CECELIA SYLVIA</u> | | | | 2. DATE AND HOUR OF DEATH
<u>April 24, 1966</u> <u>12</u> <u>40</u> <u>9</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Lutheran Hospital of Maryland</u> | | (If not in hospital or institution, give street address or location) | | A. STATE
<u>MARYLAND</u> | | B. COUNTY
<u>15-11</u> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>3645 WABASH AVENUE</u> | | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>white</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | | 8. DATE OF BIRTH
<u>1/30/1910</u> | 9. AGE (In years last birthday)
<u>56</u> | If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>AT HOME</u> | | 11. BIRTHPLACE (State or foreign country)
<u>NEW YORK, NEW YORK</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>LOUIS SIEGALL</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>SARAH HEYISON</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>214-50-0271</u> | | 17. INFORMANT
<u>MR. GEORGE BLINCHIKOFF</u> ADDRESS
<u>3645 WABASH AVE</u> | | | |
| 18. <u>153.8 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
<u>barium water</u>
<u>ba of the colon</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
<u>barium water</u>
<u>ba of the colon</u>
INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
1 Month () Day () Year () Hour () | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3. 9</u> 19 <u>66</u> to <u>4. 24</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4. 24</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>[Signature]</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>APRIL 24, 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>GRUMBERG IOSEF</u> | | | | 23D. ADDRESS
<u>Lutheran Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>4/26/66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>HEBREW FRIENDSHIP</u> | | 24D. LOCATION (City, town, or county) (State)
<u>BALTIMORE, MARYLAND</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 27 1966</u> | | 25B. NAME OF REGISTRAR
<u>[Signature]</u> | | 25C. FUNERAL DIRECTOR
<u>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD</u> | | | |

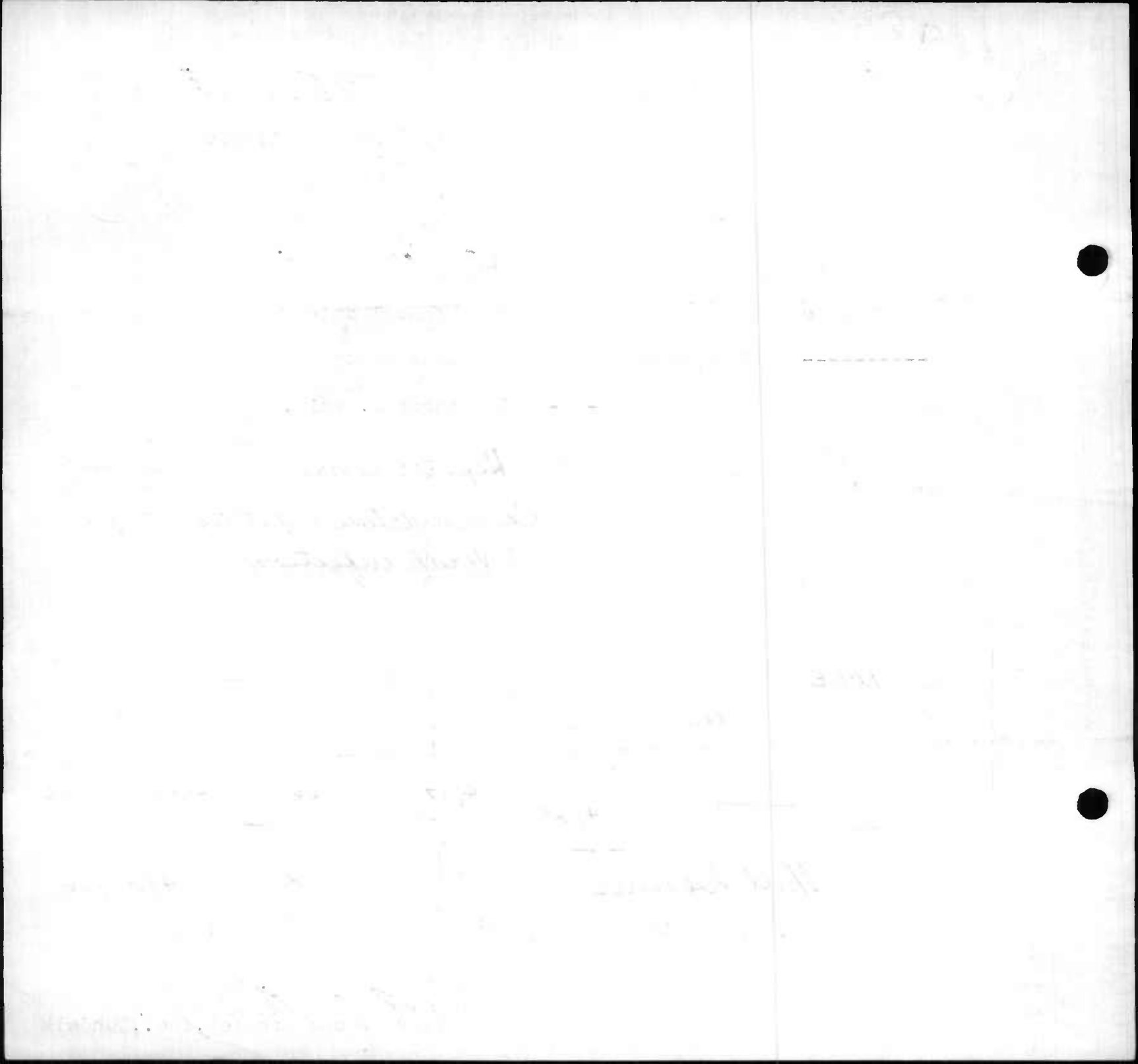


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

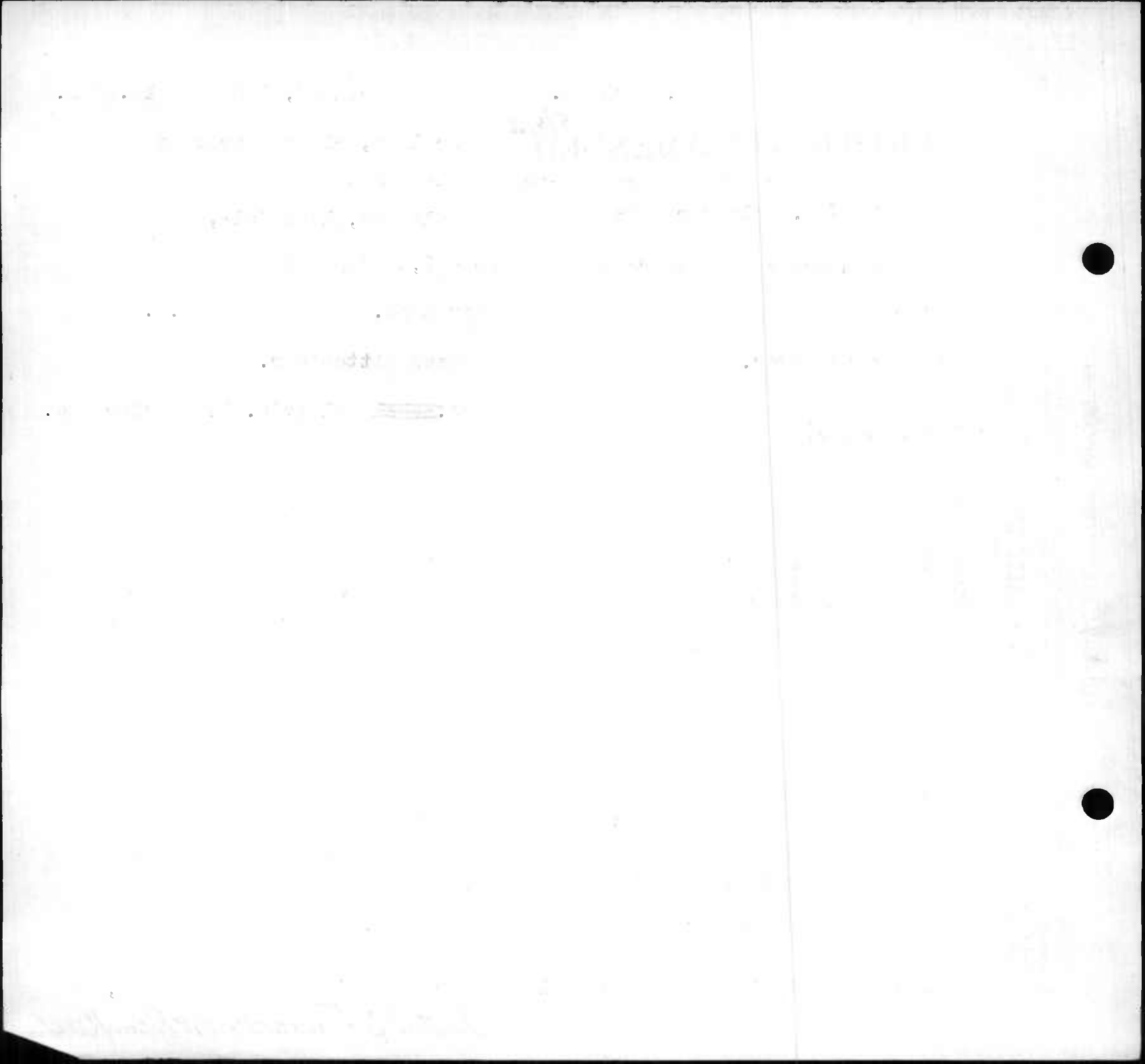
| | | | |
|---|------------------|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 86 04289 | |
| A. 520
BIRTH NO. 86 04289 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print) Amig, Costume | | 2. DATE AND HOUR OF DEATH
4/25/66 @ 8:10 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Tobias Hopkins Hosp | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Bethesda, Md
D. STREET ADDRESS (If rural, give location) 938 Garrison Drive | |
| 5. SEX W | 6. RACE F | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W | 8. DATE OF BIRTH 4/7/05 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 61 |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas-Adam Waldo Walter | | 14. MOTHER'S MAIDEN NAME Alice Felty | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 219-18-4299 | |
| 17. INFORMANT Monroe S. Amig, same as #4 | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
1092X I
Hepatic coma | | INTERVAL BETWEEN ONSET AND DEATH ? 2 weeks | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Chronic active hepatitis 3 years
(C) ? Viral infection | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 0 NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/17 19 66 to 4/25 19 66 , that (I) (we) last saw the deceased alive on 4/25 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE M. A. Dennis | | 23B. DATE SIGNED 4/25/66 | |
| 23C. PHYSICIAN'S NAME (Type) M. A. Dennis | | 23D. ADDRESS M.D. The Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4/28/66 | |
| 24C. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial | | 24D. LOCATION (City, town, or county) (State) Dorsey, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 27 1966 | | 25B. NAME OF REGISTRAR Robert E. Farley | |
| 25C. FUNERAL DIRECTOR Walter Brooks Bradley, Inc. | | ADDRESS Dundalk | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

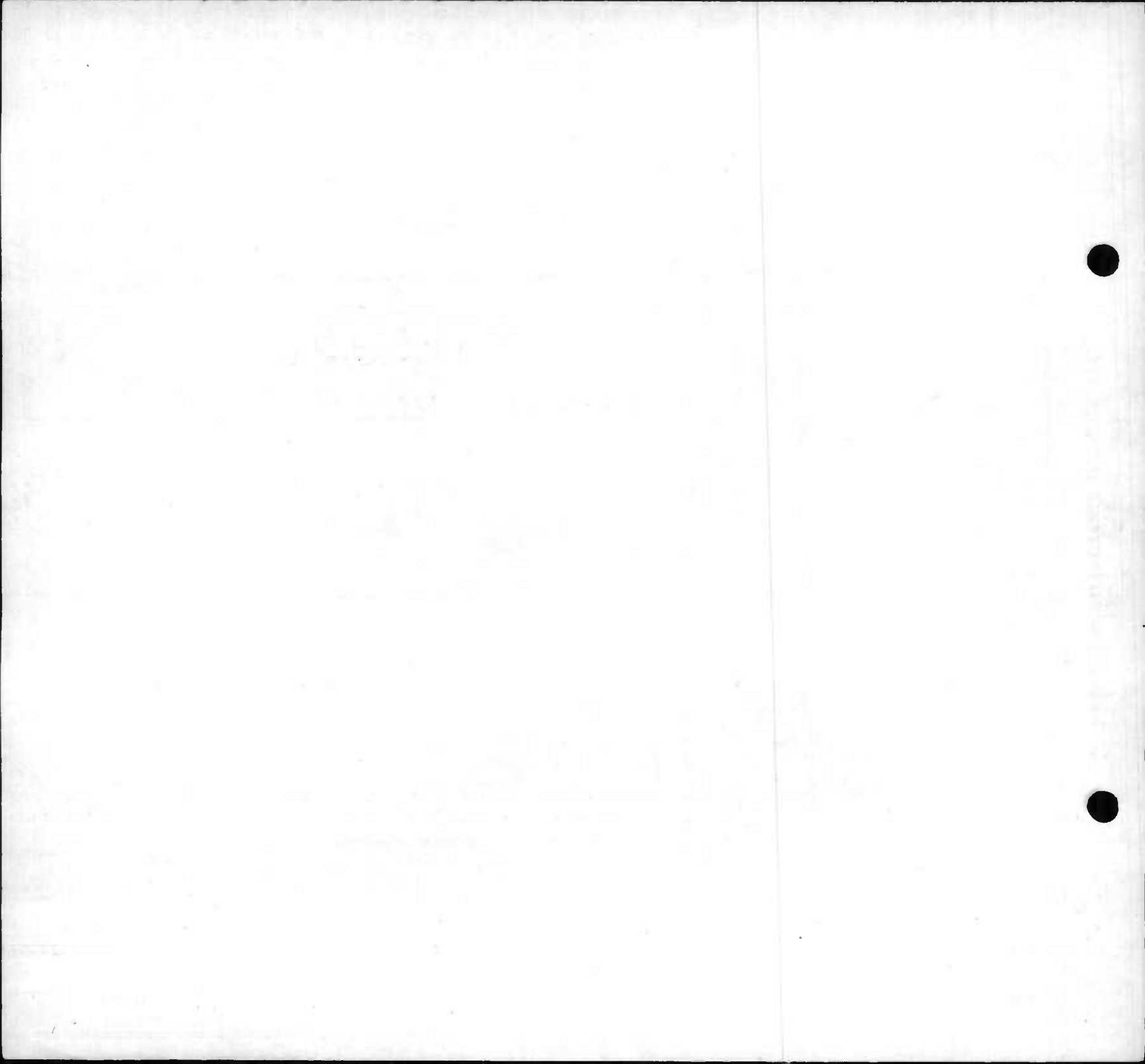
| | | | | | |
|--|-------------------------|---|---|--|---|
| BIRTH NO. 68 04270 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04270 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) Elizabeth M. Carlson. | | | 2. DATE AND HOUR OF DEATH
April 25, 1966 12.20 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
House In The Pines Nursing Home
2525 W. Belvedere Ave | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland, Prince George Co
B. COUNTY Glenn Dale
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Glenn Dale
D. STREET ADDRESS (If rural, give location) Duval Ave, Glenn Dale, Md GLENNDALE | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Divorced | 8. DATE OF BIRTH
June 2, 1889 | 9. AGE (In years last birthday)
76 | If Under 1 Yr. Months Days Hours
If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland. | |
| 13. FATHER'S NAME
Thomas Mayer. | | | 14. MOTHER'S MAIDEN NAME
Susan Tittensour. | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
? | | 17. INFORMANT
Dorothy Leah
Mrs. Mabel Valdivia, 5904 Harford Rd. | |
| 18. 746X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Chronic Hypertension
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Generalized Atherosclerosis | | | CAUSE OF DEATH
(A) Chronic Hypertension
(B) Generalized Atherosclerosis
(C) _____ | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
6 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 24 19 66 to April 25 19 66 , that (I) (we) last saw the deceased alive on April 24 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Daniel J. Schwartz | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/25/66 |
| 23C. PHYSICIAN'S NAME (Type)
DANIEL J. SCHWARTZ | | | 23D. ADDRESS
4000 W Northern Parkway | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/27/66 | | 24C. NAME OF CEMETERY or CREMATORY
Cedar Hill Cemetery | |
| 24D. LOCATION
5829 Ritchie Highway, Md | | (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1966 | | 25B. NAME OF REGISTRAR
Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR
Austin E. Donovan - 3818 Bladensburg | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|--|--|---|
| BIRTH NO. 66 04271 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04271 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) KELLNER, PIERCE | | | 2. DATE AND HOUR OF DEATH
April 23, 1966 5:30 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE MD B. COUNTY Balto | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
48 Maryland Gen. Hospital | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 3300 | | |
| | | | D. STREET ADDRESS (If rural, give location)
7525 Carson Ave | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Married | 8. DATE OF BIRTH
Feb 10 1910 | 9. AGE (In years last birthday)
56 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Steel Worker | | 10B. KIND OF BUSINESS OR INDUSTRY
Steel Worker | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
US |
| 13. FATHER'S NAME
GEORGE, KELLNER | | | 14. MOTHER'S MAIDEN NAME
Elsie Goetz | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-07-3721 | 17. INFORMANT
Addie O. Kellner | | ADDRESS
7525 Carson Ave Balto. MD |
| 18. 181.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Metastatic ca of bladder | | | INTERVAL BETWEEN ONSET AND DEATH
April 21, 1966 to April 23, 1966 | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO
(B) DUE TO
(C) DUE TO | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-21 19 66 to April 23 19 66 , that (I) (we) last saw the deceased alive on April 23 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Youngsik Moon | | | | 23B. DATE SIGNED
April 23, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
YOUNGSIK MOON | | 23D. ADDRESS
M.D. Maryland Gen. Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-27-66 | | 24C. NAME OF CEMETERY or CREMATORY
OAK Lawn Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1966 | | 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR
Philip E. Snoch 1211 Chesaco Ave | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Michael Cole

2. DATE AND HOUR PRONOUNCED DEAD

April 22, 1966 9:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Balto

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

13 Whitethorn Way

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

3/14/97

9. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Standard Oil - Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Michael Cole

14. MOTHER'S MAIDEN NAME

Theresa Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

214-01-4292

17. INFORMANT

ADDRESS

Wife (Same as above)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-22-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/25/66

23C. NAME of CEMETERY or CREMATORY

Gardens of Faith

23D. LOCATION

Balto.

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 27 1966

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Connelly Sons

ADDRESS

300 Macd Ave. Balto. 21

VALLEY POLICE

INVESTIGATION REPORT
NO. 100-100

Yes

46-35-69 1
NIW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <u>R 262</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>66 04273</u> | |
|--|-----------------------------|---|------------------------------------|---|---|
| M.E. CASE NO. <u>66 04273</u> | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>FREDERICK E. ROGERS</u> | | 2. DATE AND HOUR OF DEATH
<u>APRIL 24, 1966 6:40 P.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>BALTIMORE CITY HOSPITALS</u>
<u>4940 EASTERN AVE, BALTO. MD 21224</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MARYLAND</u> B. COUNTY <u>ANNE ARUNDEL</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>ANNA POLIS</u>
D. STREET ADDRESS (If rural, give location)
<u>307 5th Street 21403</u> | | | |
| 5. SEX
<u>MALE</u> | 6. RACE
<u>CAUCASIAN</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>7-27-94</u> | 9. AGE (In years last birthday)
<u>71</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Ret.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Civil Service</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | |
| 13. FATHER'S NAME
<u>FREDERICK A. ROGERS</u> | | 14. MOTHER'S MAIDEN NAME
<u>JULIA F. MASON</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<u>RECORDS BCH 4940 Eastern Ave. Balto. Md. 21224</u> | |
| 18. <u>420.11</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.)
<u>Cerebrovascular Accident</u> | | CAUSE OF DEATH
(A) DUE TO
<u>Cerebrovascular Accident</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 Hours</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>GI Bleeding - Unknown Etiology</u> | | (B) DUE TO
<u>Acute Myocardial Infarction</u> | | <u>48 Hours</u> | |
| | | (C) DUE TO
<u>Arteriosclerotic Cardiovascular Disease</u> | | <u>14 Years</u> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>GI Bleeding - Unknown Etiology</u> | | | | <u>5 MONTHS</u> | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>APRIL 4</u> 19 <u>66</u> to <u>APRIL 24</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>APRIL 24</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>James T. Sparks</u> M.D. | | | | 23B. DATE SIGNED
<u>April 24, 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>JAMES T. SPARKS</u> M.D. | | | | 23D. ADDRESS
<u>4940 Eastern Ave., Balto. Md. 21224</u>
<u>BALTIMORE CITY HOSPITALS</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4-28-66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>GLEN HAVEN</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>GLEN BURIE MD.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 27 1966</u> | | 25B. NAME OF REGISTRAR
<u>John M. Taylor</u> | |
| 25C. FUNERAL DIRECTOR
<u>ANNAPOLIS, MD.</u> | | 25D. ADDRESS
<u>ANNAPOLIS, MD.</u> | | | |

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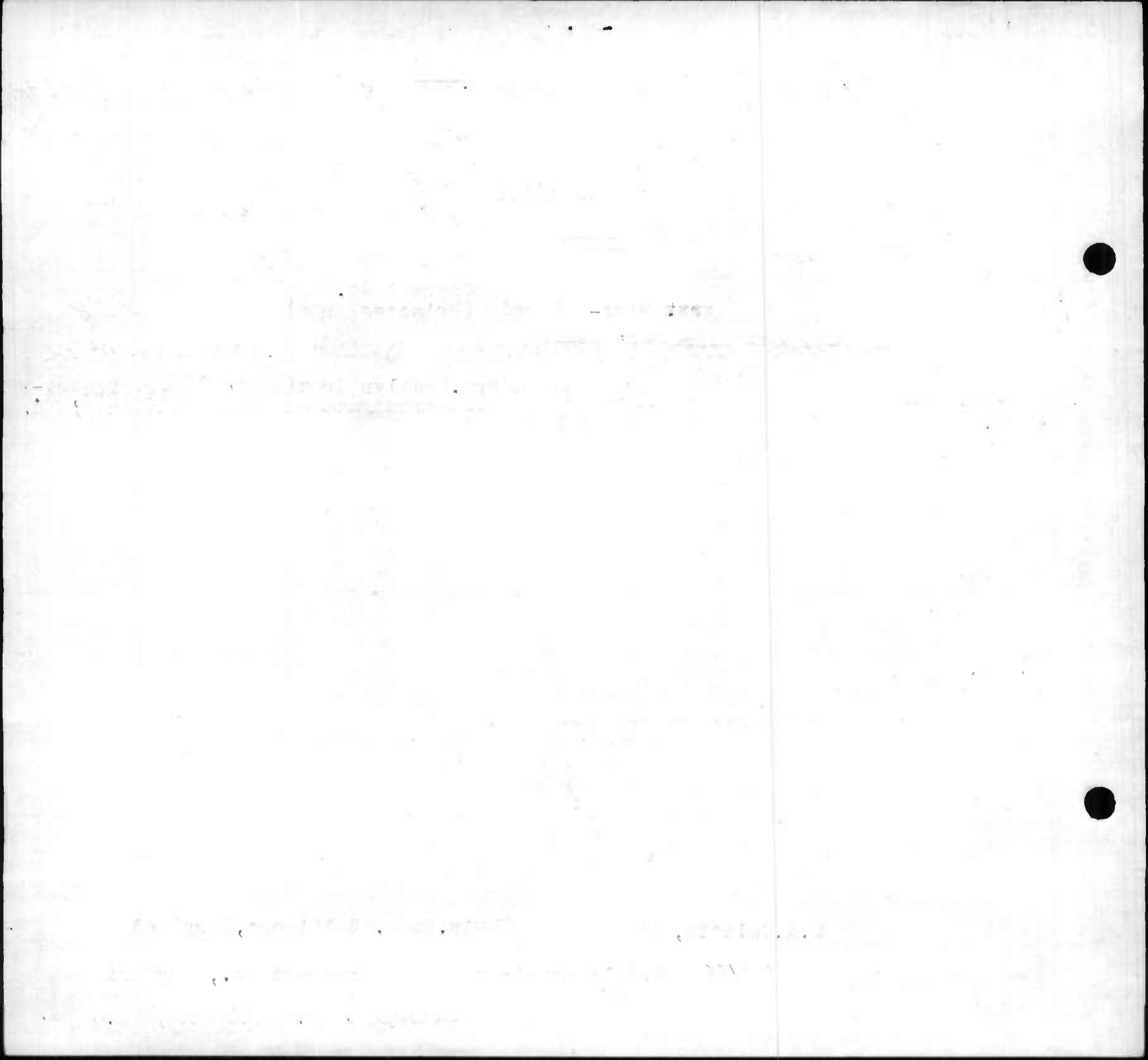
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Certificate of Death | | Registered No. <u>66 04274</u> | |
|---|---------------------|--|--|---|--|--|--|
| BIRTH NO. <u>66 04274</u> | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>BEDSWORTH, VIRGINIA</u> | | 2. DATE AND HOUR OF DEATH
<u>4/22/66</u> <u>9:08AM</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence, before admission)
A. STATE <u>MD</u> B. COUNTY <u>Balt</u> | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>UNIVERSITY Hospital</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTO 10</u> | | | | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>6178 ALLWOOD CT</u> | | | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, <u>DIVORCED</u> (specify) | | 8. DATE OF BIRTH
<u>4/27/12</u> | 9. AGE (In years last birthday)
<u>53</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>LPN</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Ret Nurse-Retired</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Somerset Co. Maryland (Princess Anne)</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>GEORGE HENRY BEDSWORTH</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>SALLY JANE WINDSOR</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>214-10-1636</u> | | 17. INFORMANT
<u>Mrs. Madelyn Orem (Sister)</u> | | ADDRESS
<u>6609 Wycombe - wa Baltimore, Md.</u> | |
| 18. <u>154X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <u>METASTATIC - CA</u>
DUE TO
(B) <u>PECTAL CA</u>
DUE TO
(C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<u>4/4/66</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>TO RELIEVE PAIN</u> | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/28/66</u> 19 <u>66</u> to <u>4/22/66</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/22</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>D. A. Culotta</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>4/22/66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>D.A. Culotta, MD</u> | | | | 23D. ADDRESS
M.D. <u>Univ. Hosp. Baltimore, Maryland</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>burial</u> | | 24B. DATE
<u>4/25/66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Oriole Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Somerset Co., Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 27 1966</u> | | 25B. NAME OF REGISTRAR
<u>R. E. Farley, MA</u> | | 25C. FUNERAL DIRECTOR
<u>Holloway & Rock Salisbury, Md.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 88 04275 | |
|--|--|---------------------|--|---|--|--|--|--|--|--|--|
| BIRTH NO. 88 04275 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) ELbert Clarence Sauter | | | | | | 2. DATE AND HOUR OF DEATH
4/25/66 5¹⁵ P. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 19-04 | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital Balt. Md. | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Balto. zone 23 | | | | | |
| D. STREET ADDRESS (If rural, give location)
434 S. Gilmore St. | | | | | | | | | | | |
| 5. SEX
Male | | 6. RACE
W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
10/3/09 | | 9. AGE (In years last birthday)
56 | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Warehouseman | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Clarence Sauter | | | | | | 14. MOTHER'S MAIDEN NAME
Mabel Timuans | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNKNOWN | | | | 16. SOCIAL SECURITY NO.
? | | 17. INFORMANT ADDRESS
H. Stoner University Hospital | | | | | |
| 18. 421.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Calcific Aortic Stenosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Years | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/23/66 19 66 to 4/25/66 19 66 , that (I) (we) last saw the deceased alive on 4/25/66 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Robert E. Stoner, MD | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/25/66 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Robert E. Stoner | | | | | | 23D. ADDRESS
M.D. University Hospital Balt. Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | 24B. DATE
4/29/66 | | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral Cms | | | | 24D. LOCATION (City, town, or county) (State)
Balto Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1966 | | | | 25B. NAME OF REGISTRAR
Robert E. Stoner, MD | | | | 25C. FUNERAL DIRECTOR ADDRESS
Thomas J. Kenny Inc Balt Md | | | |

2nd Street - University of California

X

Robert E. Brown

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN T. FLYNN, Sr.

2. DATE AND HOUR PRONOUNCED DEAD

April 25, 1966 6:32 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

4500 Old Frederick Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4500 Old Frederick Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widowed June 12/99

8. DATE OF BIRTH

June 12/99

9. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Long Shareman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Patrick Flynn

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Michael P. Flynn

ADDRESS

402 Calleson Rd
29

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cardio-respiratory insufficiency
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Carcinoma of Lung, Emphysema, and
~~XXX~~

(C) Arteriosclerotic Cardiovascular Disease.

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/26/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/29/66

23C. NAME of CEMETERY or CREMATORY

New Cathedral

23D. LOCATION

(City, town, or county)

(State)

Deeto. Md

24A. DATE REC'D BY HEALTH DEPT.

APR 27 1966

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Walter V. 4101 Edmondson Ave

ADDRESS

VALLEY FORD

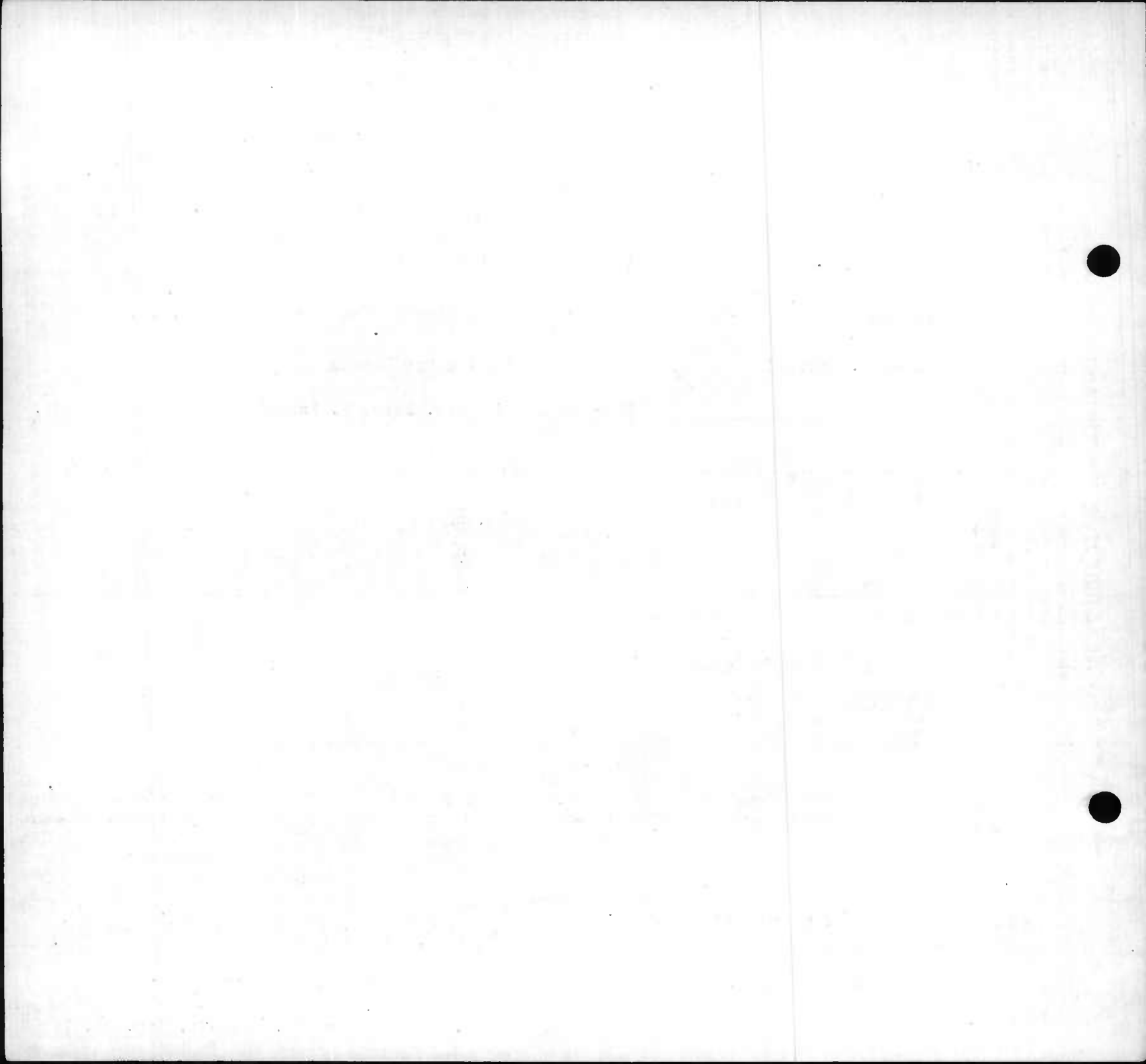
ROAD CONTINUED

U.S.A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>86 04278</u> | |
|--|---------------------|---|--|--|---|
| BIRTH NO. <u>86 04278</u> | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <u>HARROLL, JOHN F.</u> | | | 4.25.66. 3-30 PM. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>LUTHERAN HOSPITAL OF MARYLAND.</u>
<u>730 - ASHBURTON STREET.</u>
<u>BALTIMORE. MD. USA.</u> | | | A. STATE
<u>1412 - Homestead Street.</u>
B. COUNTY
<u>BALTIMORE.</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>9-05</u>
D. STREET ADDRESS (If rural, give location)
<u>1412 - Homestead Street. BALTIMORE. MD.</u> | | |
| 5. SEX
<u>M.</u> | 6. RACE
<u>C</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
<u>M.</u> | 8. DATE OF BIRTH
<u>11-7-02</u> | 9. AGE (In years last birthday)
<u>63.</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Maryland</u> | |
| 13. FATHER'S NAME
<u>James T. Harroll</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Ida May Norris</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>214-14-5209</u> | | 17. INFORMANT
<u>Mrs. Hazel M. Harroll</u> ADDRESS
<u>1412 Homestead St.</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>260X I</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH
(A) <u>Uremia.</u>
DUE TO
(B) <u>Diabetes Mellitus.</u>
DUE TO
(C) <u>Cong. Cardiac Failure.</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>4 months.</u> | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>NO Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3-30-1966</u> to <u>4-25-1966</u> , that (I) (we) last saw the deceased alive on <u>4-25-1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Laviza Mahmood,</u> | | | | 23B. DATE SIGNED
<u>4-25-66.</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>LAVIZA MAHMOOD,</u> | | | | 23D. ADDRESS
<u>LUTHERAN HOSPITAL OF MARYLAND.</u>
<u>BALTIMORE.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/28/66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>New Cathedral Cemetery</u> | |
| 24D. LOCATION
<u>Baltimore, Maryland</u> | | 24E. (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 27 1966</u> | | 25B. NAME OF REGISTRAR
<u>R. E. Farley</u> | | 25C. FUNERAL DIRECTOR
<u>Wm. Cook-Brooks Inc.</u> ADDRESS
<u>1217 St. Paul St. 21202</u> | |



1
A 536

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04279

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ARTHUR ANDERSON

2. DATE AND HOUR PRONOUNCED DEAD

April 25, 1966 7:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE North Carolina

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Elizabeth City

D. STREET ADDRESS (If rural, give location)

205 Poole Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Nov. 29, 1925

9. AGE (In years
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Seamen

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Norfolk, Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unk.

14. MOTHER'S MAIDEN NAME

Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL
SECURITY NO.

244-26-2903

17. INFORMANT

ADDRESS

Mrs. Linda K. Anderson 730 N. Howard St. 21201

18.

E 900.6 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Craniocerebral injury

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

lodging home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

426½ E. Pratt St.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

April 16, 1966 5:00 P.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

fell down flight of stairs

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/26/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/29/66

23C. NAME of CEMETERY or CREMATORY

Baltimore, National

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 27 1966

Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202

VALLEY POLICE

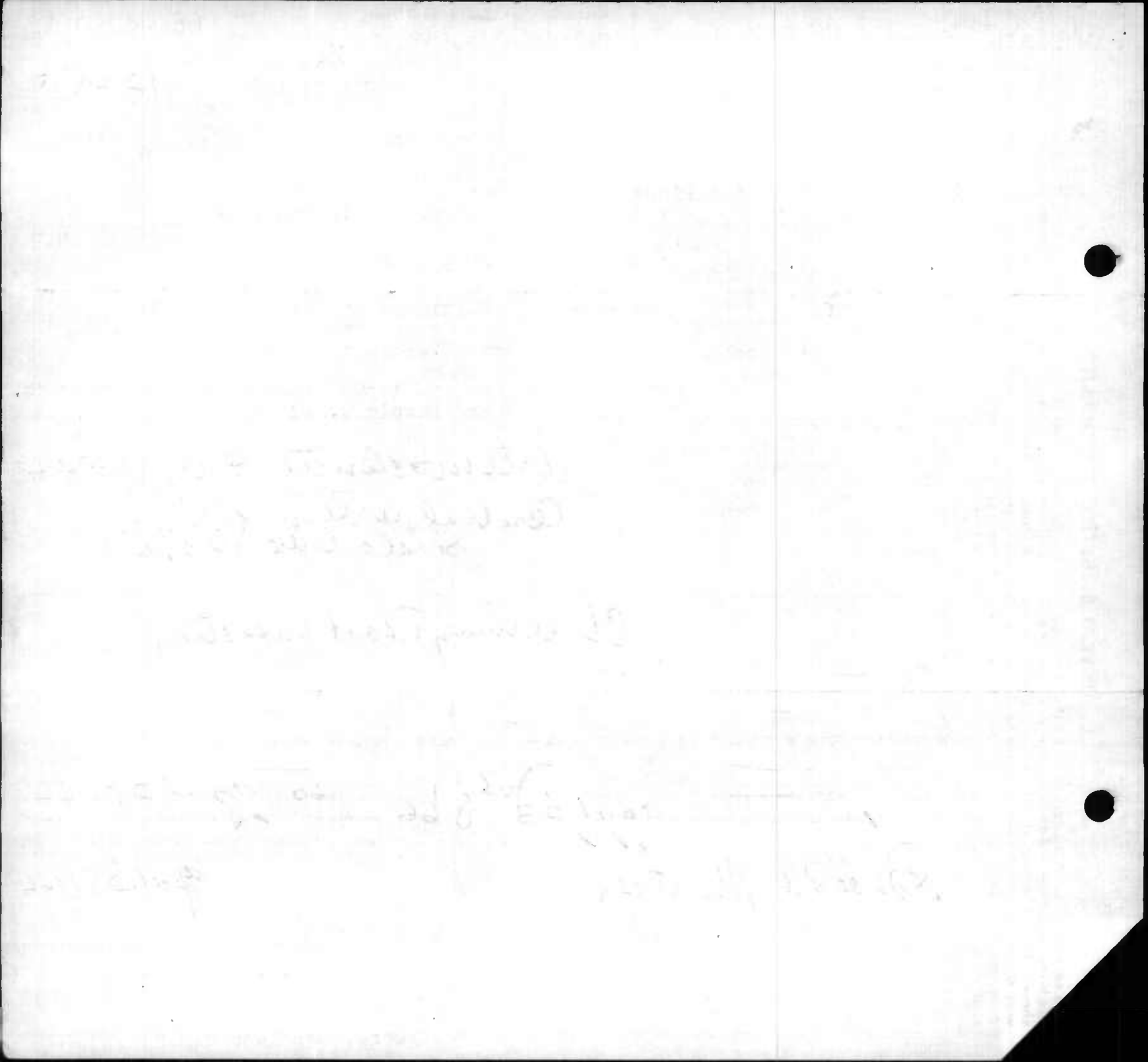
CHAD CONTENT

1-1-1

FUNERAL DIRECTOR: IMPORTANT

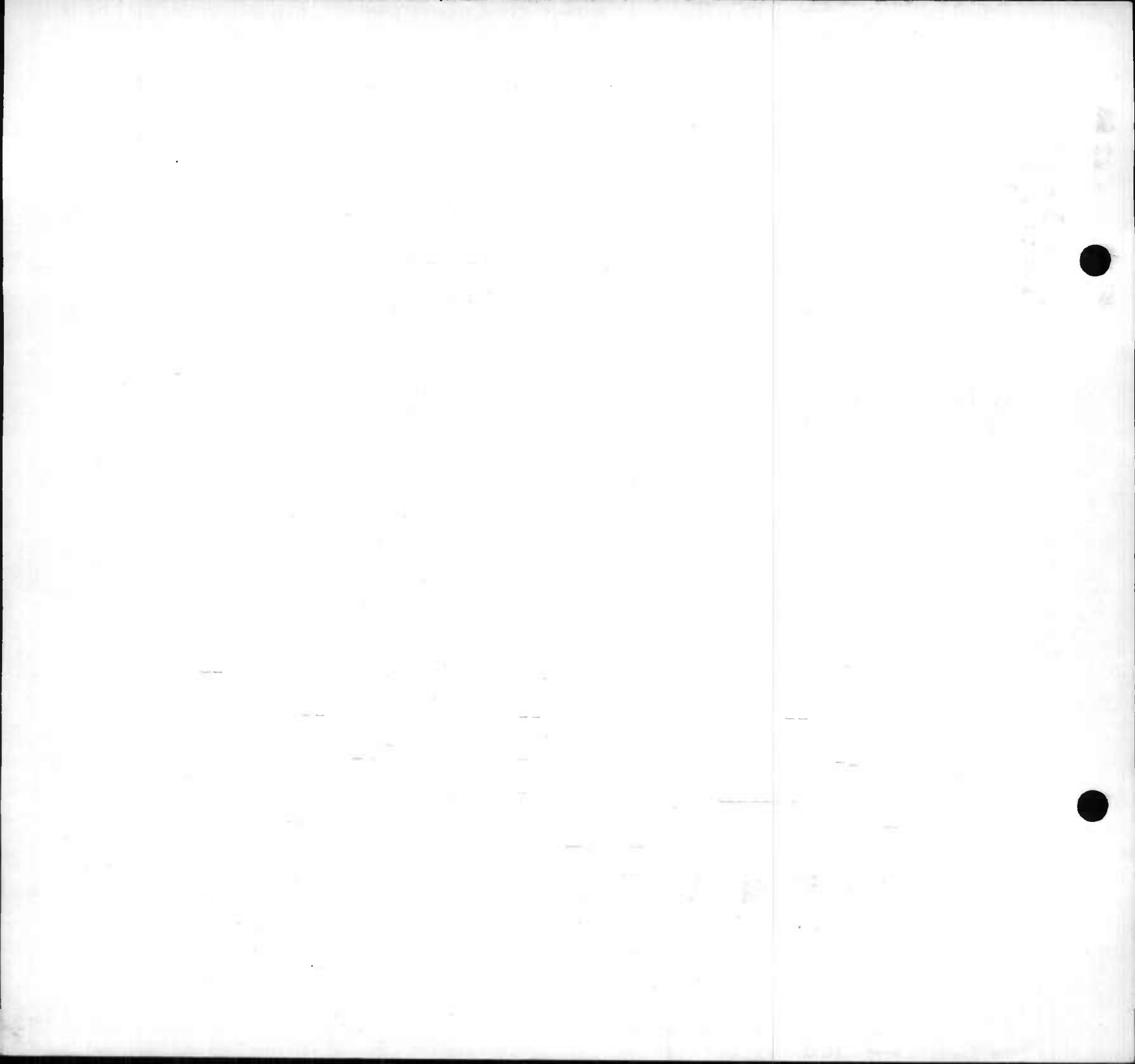
he must be approved by the chief medical examiner or his assistant if death occurred in a hospital and released to the hospital by a medical examiner. Also, if the direct or contributing cause of death is accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 04280 | |
|--|------------|--|-------------------------------|--|----------------------------|--|-----------------------------|
| BIRTH NO. 66 04280 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ANNA BORCHARDT | | 2. DATE AND HOUR OF DEATH APRIL 25, 1966 11:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) House in the Pines 5837 Belair Rd. | | | | A. STATE Maryland | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Bowie | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 12500 Kensington Lane | | | |
| 5. SEX F. | 6. RACE W. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH July 1, 1892 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY at Home | | 11. BIRTHPLACE (State or foreign country) Baltimore Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Michael Boehm | | | | 14. MOTHER'S MAIDEN NAME Margaret Porlein | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs Bernie W. Bjerk | | ADDRESS 12500 Kensington Lane Bowie Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | Arteriosclerotic Heart Disease | | | |
| | | | | Cerebral arteriosclerosis (Small Lobe Strokes) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Ch urinary Tract Infection | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 1, 1960 to April 25, 1966, that (I) (we) last saw the deceased alive on April 23, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Donald W. Mintzer | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED April 25, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) Donald W. Mintzer | | | | 23D. ADDRESS 3009 Evergreen Avenue | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4/27/66 | | 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 27 1966 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Henry Sander & Sons Inc. | | ADDRESS Baltimore, Maryland 21213 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undue physical exertion; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | | | Registered No. <u>66 04281</u> | |
|---|-------------------------|---|------------------------------------|---|--|--|--|
| BIRTH NO. <u>66 04281</u> | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>John DeAngelis (DeFillippo)</u> | | | | 2. DATE AND HOUR OF DEATH
<u>4-22-66</u> <u>7:20</u> a.m. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>The Johns Hopkins Hospital</u> | | (If not in hospital or institution, give street address or location) | | A. STATE
<u>Maryland</u> | | B. COUNTY
<u>Baltimore</u> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>1630 Chesco Avenue</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Widower</u> | 8. DATE OF BIRTH
<u>2-11-83</u> | 9. AGE (In years last birthday)
<u>83</u> | If Under 1 Yr.
Months Days Hours Min. | If Under 24 Hrs.
Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>R.R.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Retired</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Italy</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Vincent</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>—</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>—</u> | | 17. INFORMANT
<u>Mr. De Angelis (son)</u> | | ADDRESS | |
| 18. <u>4-22-66</u> CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. If means the disease, injury or complication which caused death.)
<u>ASCVD #333</u> | | | | <u>years</u> | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Urinary tract infection</u> | | | | <u>months</u> | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<u>3/18/66</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>prostatic hyperplasia</u> | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>—</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)
<u>—</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
<u>—</u> | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
<u>—</u> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<u>—</u> | | | |
| 22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>4/6/</u> 19 <u>66</u> to <u>4/22/</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/21</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (<u>did</u>) (<u>did not</u>) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Robert I. Keimowitz</u> M.D. | | | | | | 23B. DATE SIGNED
<u>4/23/66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Robert I. Keimowitz</u> M.D. | | | | 23D. ADDRESS
<u>Johns Hopkins Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/25/66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>St. Stanislaus</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Balt. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 27 1966</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Farley</u> | | 25C. FUNERAL DIRECTOR
<u>Joseph N. Zanning</u> | | ADDRESS
<u>263 S. Conley St.</u> | |



86 04282

BALTIMORE CITY HEALTH DEPARTMENT

86 04282

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M 236

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

| | | | |
|---|-------------------------|--|--|
| 1. NAME OF DECEASED
(Type or Print)
FRANK MASTRIANNI | | 2. DATE AND HOUR PRONOUNCED DEAD
April 22, 1966 10:00 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
3706 Claremont Avenue | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Connecticut
B. COUNTY V-06
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Danbury
D. STREET ADDRESS (If rural, give location)
22 Westville Street | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
Feb. 8, 1900 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Tailor | | 10B. KIND OF BUSINESS OR INDUSTRY
retired | 9. AGE (In years last birthday)
66 |
| 11. BIRTHPLACE (State or foreign country)
Italy | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Pasquale Mastriani | | 14. MOTHER'S MAIDEN NAME
Josephine Mastriani | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
044-05-0726 | |
| 17. INFORMANT
Mrs. Josephine Palmere Balto., Md. | | ADDRESS | |

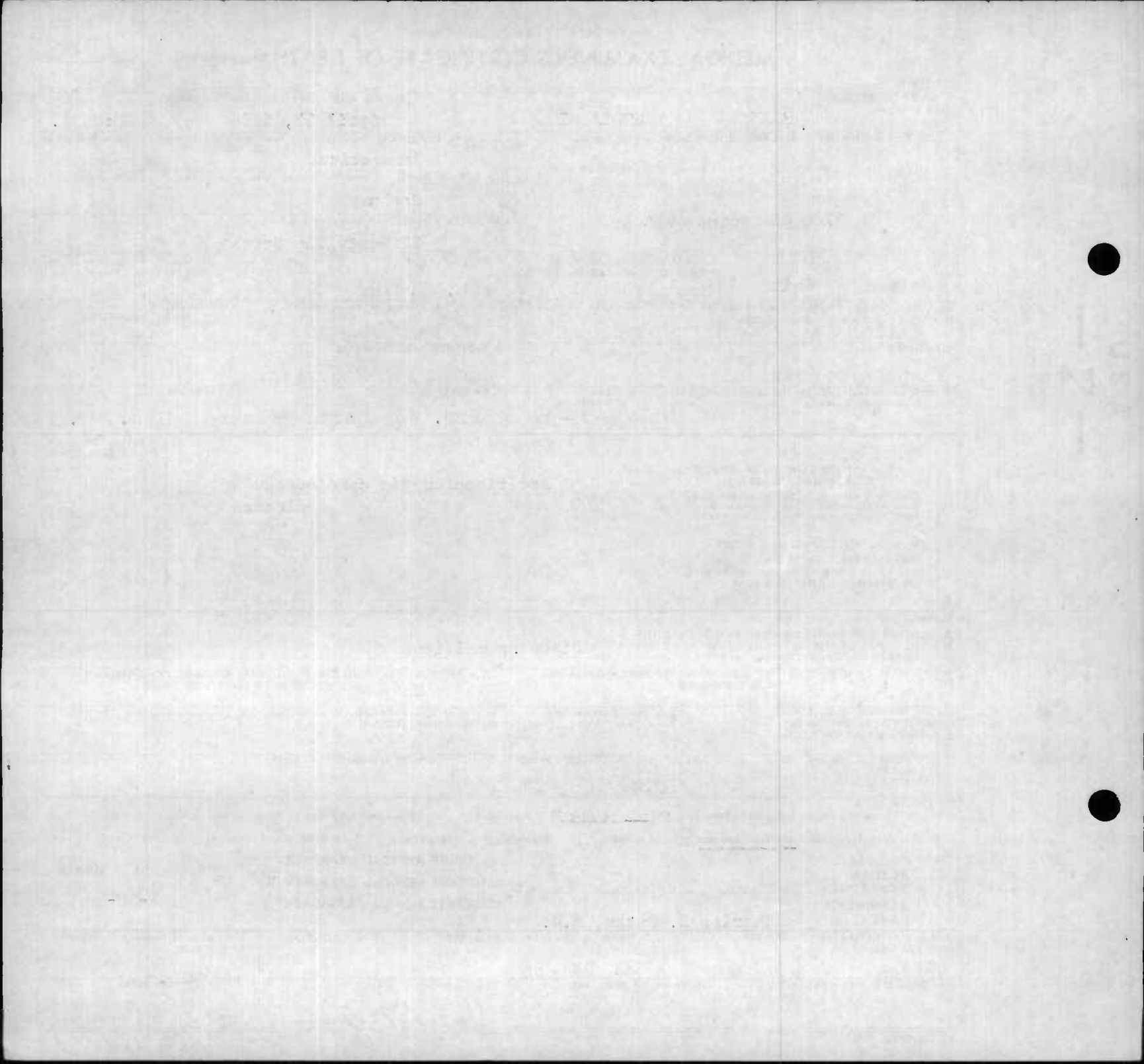
| | | | |
|-----------------------|---|---|---|
| MEDICAL CERTIFICATION | 18. CAUSE OF DEATH
422.1 & 260x
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease
(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH | | |
| | ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes mellitus | | |
| | 19A. DATE OF OPERATION
0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
No |
| | 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| | 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| | 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from:
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>

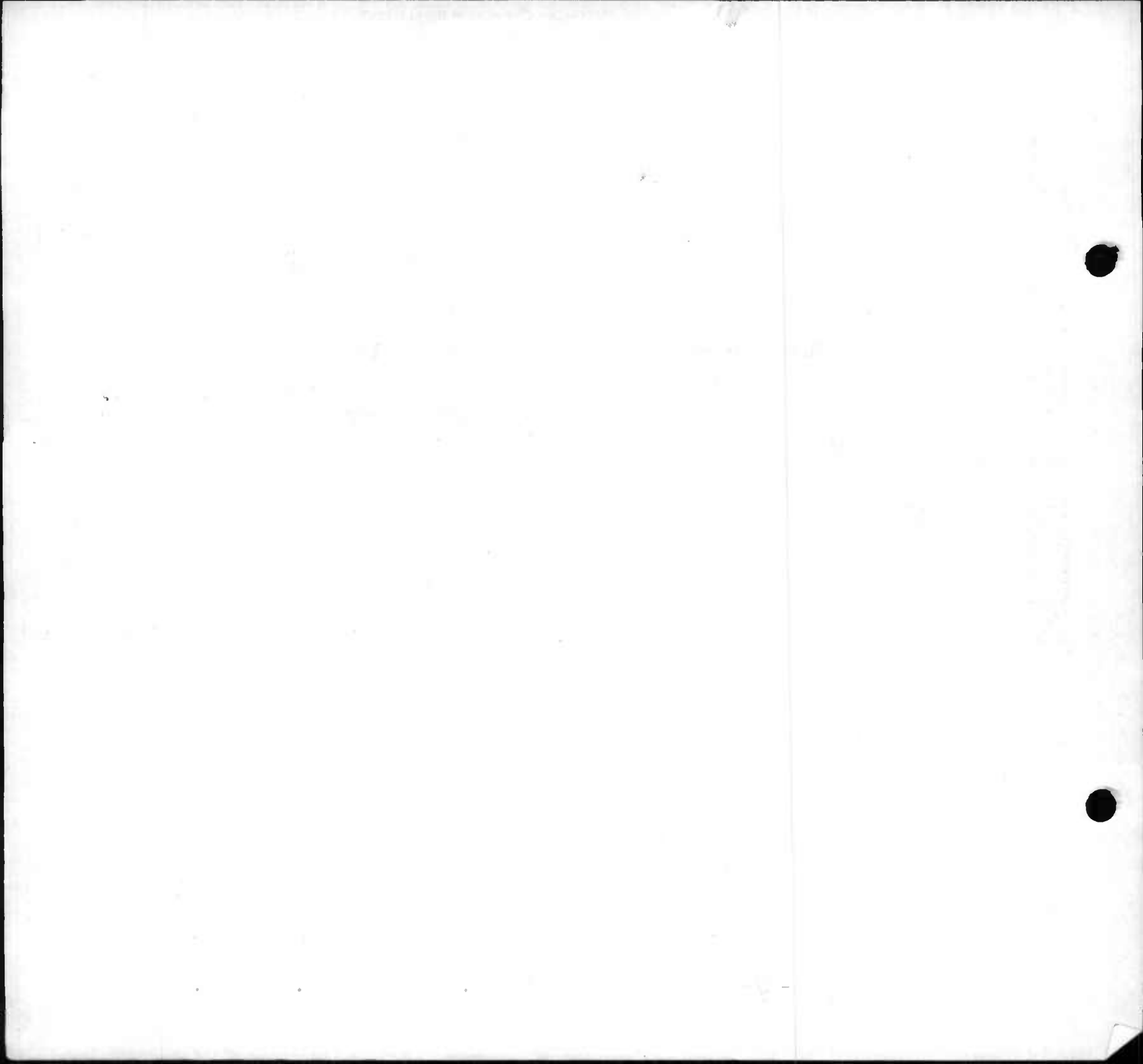
ACTUAL SIGNATURE Charles S. Petty M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) Charles S. Petty, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4-22-66 | | |
| | 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 23B. DATE
4/25/66 | 23C. NAME of CEMETERY or CREMATORY
St. Peters |
| | 24A. DATE REC'D BY HEALTH DEPT.
APR 27 1966 | 24B. NAME OF REGISTRAR
Robert E. Farley, M.D. | 24C. FUNERAL DIRECTOR
Joseph N. Zannini - 263 S. Conkling St. Balto Md. |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

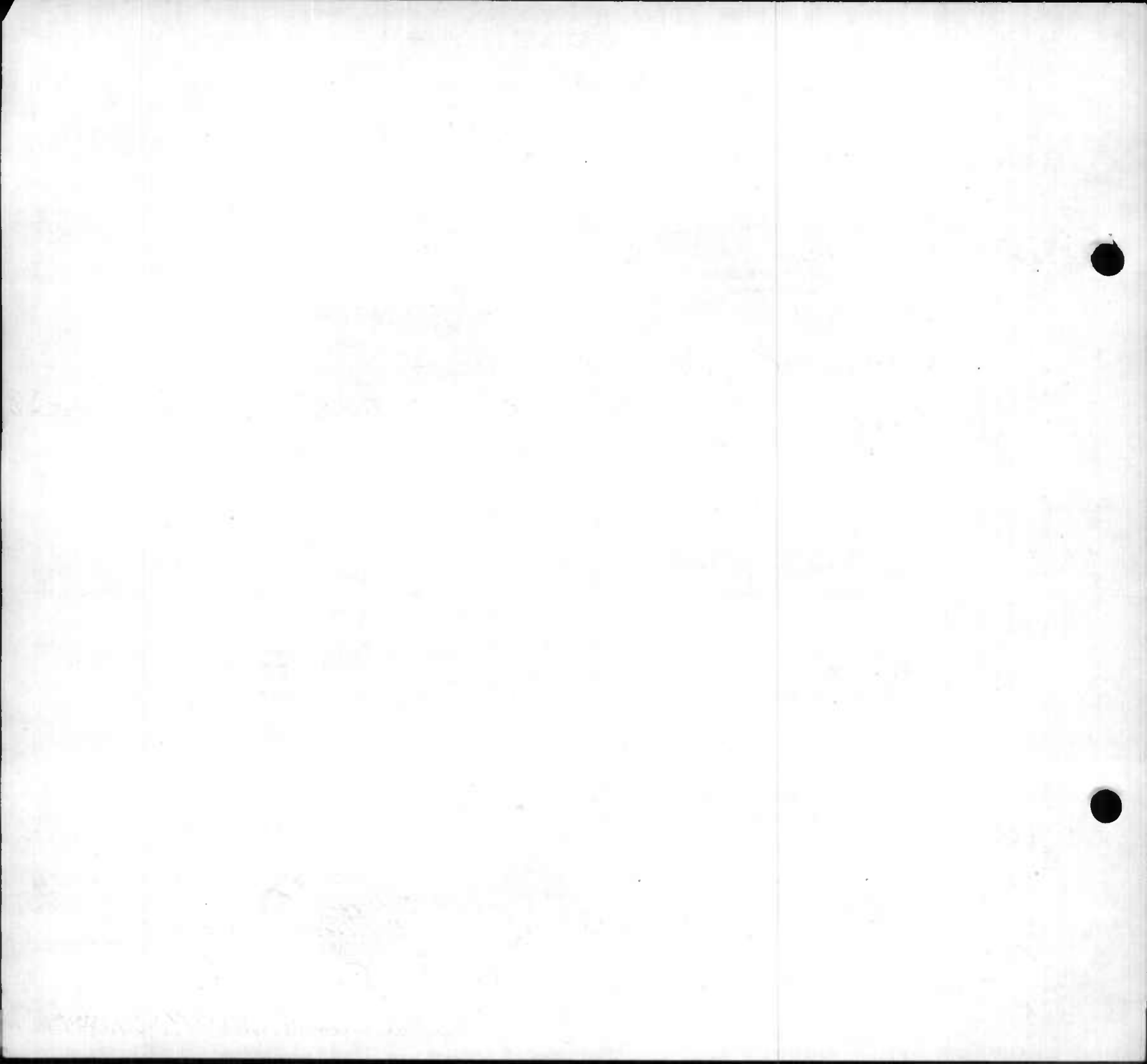
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 66 04283 | | | | |
|--|--|--------------|--|--|--|-----------------------------|------------------------------|-------------------------------------|--|--|--|-------------------------------------|--|--|
| BIRTH NO. 66 04283 | | | | | | | | | | 66 04283 | | | | |
| M.E. CASE NO. | | | | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Charles A. Murray | | | | | 2. DATE AND HOUR OF DEATH
4/23/66 11:45 A.M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Sinai | | | | | A. STATE Md. Balto 13-01 | | | | | | | | | |
| (If not in hospital or institution, give street address or location) | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
2404 Entw Place Balto. Md. | | | | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) | | | | | | | | | |
| 5. SEX
M | | 6. RACE
N | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH
6/15/92 | | 9. AGE (In years, lost birth)
73 | | 10. If Under 1 Yr. Months: Days: Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Handyman | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
Jacob Murray | | | | | 14. MOTHER'S MAIDEN NAME
Annie Blake | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
John Murray | | | | | ADDRESS
1612 McCulloh St. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
421.2 I
Tricuspid Insufficiency with Congestive Heartfailure | | | | | CAUSE OF DEATH
(A) DUE TO
ASCVD | | | | | INTERVAL BETWEEN ONSET AND DEATH
years
years | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) DUE TO | | | | | (C) DUE TO | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Bilateral Inguinal hernia, Pulmonary Embolism Suspected | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/8/66 to 4/23/66, that (I) (we) last saw the deceased alive on 4/23/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE
Donald Rice | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED
4/23/66 | | | | |
| 23C. PHYSICIAN'S NAME (Type)
Donald Rice | | | | | 23D. ADDRESS
Sinai Hospital | | | | | | | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify)
Burial | | | | | 24B. DATE
4-28-66 | | | | | 24C. NAME OF CEMETERY or CREMATORY
New Cathederal Cem. | | | | |
| 24D. LOCATION
Balto. Md. | | | | | | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1966 | | | | | 25B. NAME OF REGISTRAR
R. E. Farley | | | | | 25C. FUNERAL DIRECTOR
George Nelson | | | | |
| | | | | | | | | | | ADDRESS
1348 Calhoun St. | | | | |



FUNERAL DIRECTOR: IMPORTANT

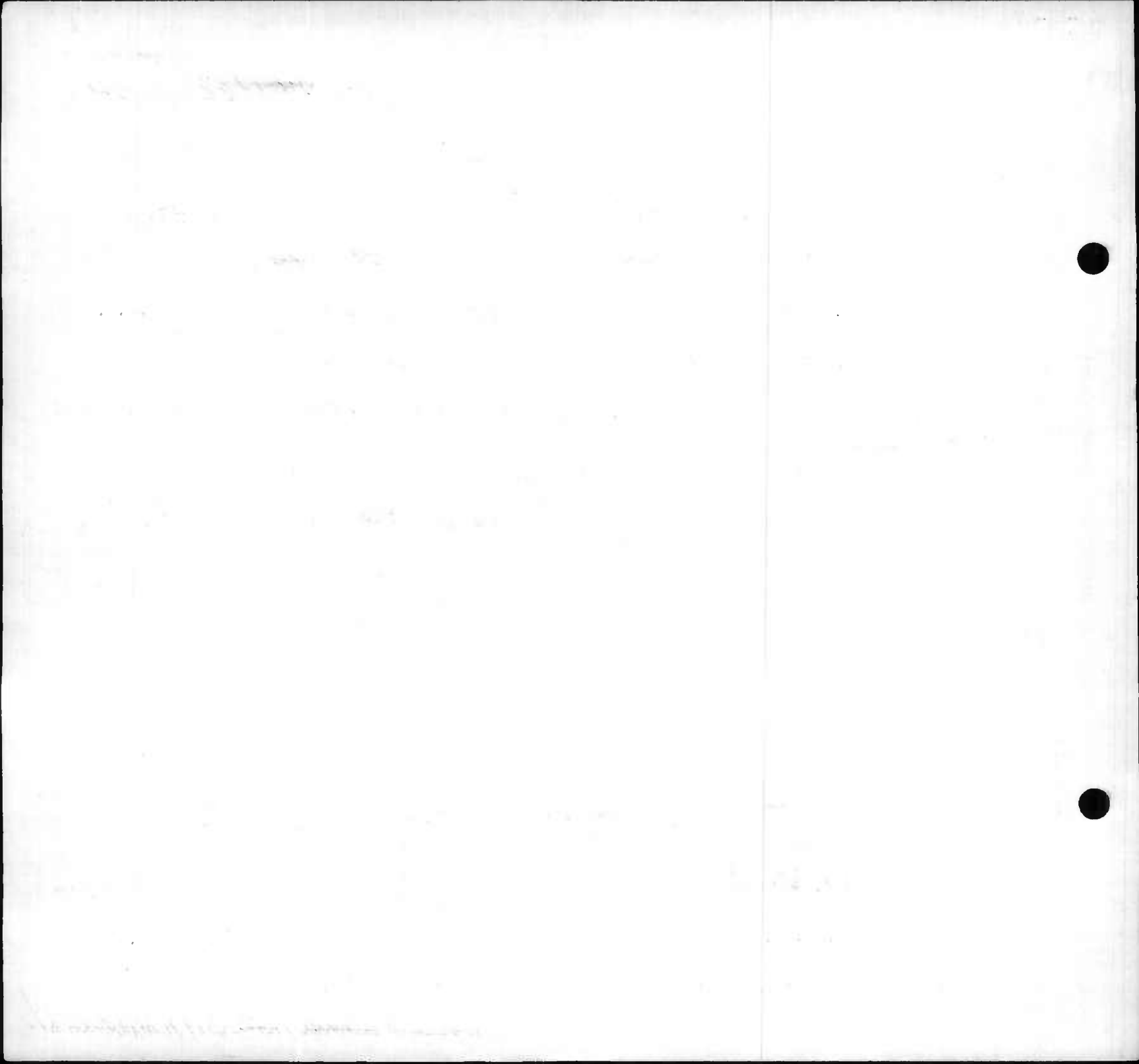
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|--|--|-------------------------|--|--|--|------------------------------------|--|--|--|---|--|-----------------------|--|------------------------|--|-----------------------|--|--|--|
| BIRTH NO. 06 04284 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 86 04284 | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) HOLMES, GENEVA | | | | | 2. DATE AND HOUR OF DEATH
April 24, 1966 9:05 A.M. | | | | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 16-07 | | | | | | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Lutheran Hospital of Maryland Baltimore, Md. 21216 | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | | | | | | | | | | | |
| D. STREET ADDRESS (If rural, give location)
1517 Poplar Grove St. | | | | | | | | | | | | | | | | | | | |
| 5. SEX
Female | | 6. RACE
Negro | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | | 8. DATE OF BIRTH
5/15/00 | | 9. AGE (In years last birthday)
65 | | If Under 1 Tr. Months | | If Under 24 Hrs. Days | | If Under 24 Hrs. Hours | | If Under 24 Hrs. Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country)
Greensboro SC. | | | | | 12. CITIZEN OF WHAT COUNTRY? | | | | |
| 13. FATHER'S NAME
John Crook | | | | | 14. MOTHER'S MAIDEN NAME
Hammott ? | | | | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | | 16. SOCIAL SECURITY NO.
578-03-0526 | | | | | 17. INFORMANT
Shirley Flight | | | | | ADDRESS
1517 Poplar Grove St. | | | | |
| 18. 570.3 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury at complication which caused death.)
Intestinal obstruction
Volvulus of sigmoid colon | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION
3/4/19/66 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Intestinal obstruction | | | | | 20A. AUTOPSY? (Yes or No)
YES. | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
April 15 1966 | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 15 1966 to April 24 1966 , that (I) (we) last saw the deceased alive on April 24 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 9:05 AM | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE
Manuel G. Fontanilla | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED
April 24, 1966 | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
Manuel G. Fontanilla | | | | | M.D. | | | | | 23D. ADDRESS
Lutheran Hospital of Maryland Baltimore, Md. 21216 | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | | 24B. DATE
4/29/1966 | | | | | 24C. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem. Balto Md. | | | | | 24D. LOCATION (City, town, or county) (State) | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1966 | | | | | 25B. NAME OF REGISTRAR
Robert E. Farber, MA | | | | | 25C. FUNERAL DIRECTOR
Williams Funeral Home | | | | | ADDRESS
319 N. Schroeder St. | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

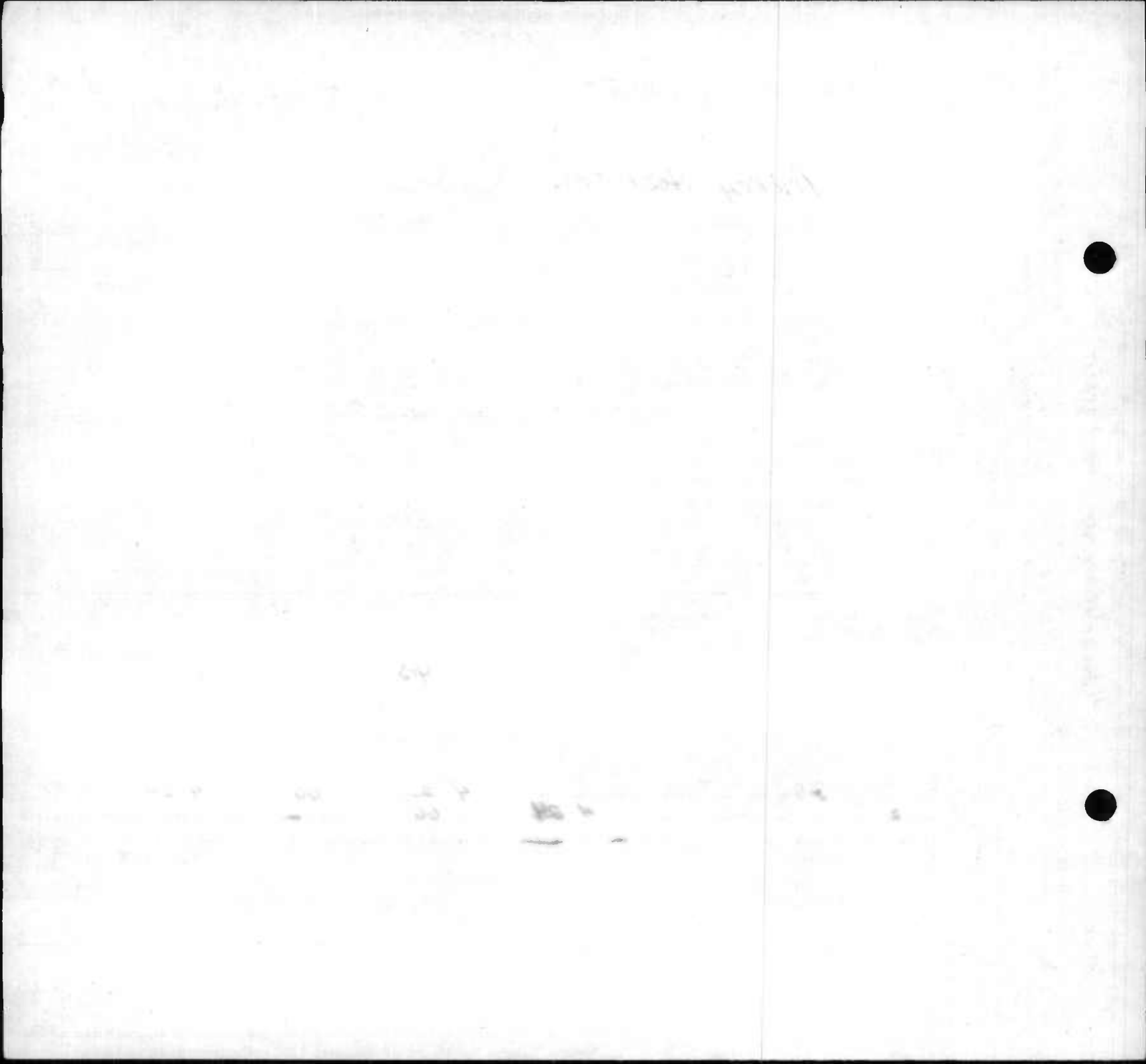
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 14285 | |
|---|--|--|--|---|--|
| R263 66 14285 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | JOHN RICHARDS | | April 24, 1966 12:40 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | |
| Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland, #21224 | | | | MD. 16-03 | |
| 5. SEX
M | | 6. RACE
N | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | |
| | | | | M | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| Miner | | | | 2/25/78 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 9. AGE (In years last birthday) | |
| Alexander Richards | | Patricia Stewart | | 88 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 11. BIRTHPLACE (State or foreign country) | |
| No | | 219-01-1993 A | | Westmoreland Co., Va. | |
| | | 17. INFORMANT | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | RECORDS: BCH, 4940 Eastern Avenue, #21224 | | U.S.A. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/15 1966 to 4/24 1966, that (I) (we) last saw the deceased alive on 4/24 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| S. D. Kreider | | | | 4/24/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| DR. S. D. KREIDER | | | | 4940 Eastern Avenue, Baltimore, Md., #21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY, CREMATORY | |
| Burial | | 4/28/66 | | Artifutis Memorial Park | |
| 25A. DATE REC'D BY HEALTH DEPT | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| APR 27 1966 | | L. E. Farley, M.D. | | Williams Funeral Home | |
| | | | | 319 N. Seneca St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | | | | | | | Registered No. <u>66 114288</u> |
|---|-------------------------|--|--|---|--|--|--|--|--|---------------------------------|
| BIRTH NO. <u>66 114288</u> | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>ALFRED P. SCOTT</u> | | | | | 2. DATE AND HOUR OF DEATH
<u>4-24-66</u> <u>8 A.M.</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Mercy Hospital</u> | | (If not in hospital or institution, give street address or location) | | | A. STATE
<u>MARYLAND</u> | | B. COUNTY
<u>Carroll</u> | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>R.D. 5 Box 290 36-00</u> | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
<u>Westminster</u> | | | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Widower</u> | | 8. DATE OF BIRTH
<u>6-26-1893</u> | 9. AGE (In years last birthday)
<u>72</u> | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Vice-Principal - High School</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Cecil Co., Md</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | |
| 13. FATHER'S NAME
<u>John T. Scott</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Annie Mannon</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | | 16. SOCIAL SECURITY NO.
<u>214-46-4129</u> | | 17. INFORMANT
<u>Scott</u> | | ADDRESS | | |
| 18. <u>350.11</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Sepsis</u> | | | | | CAUSE OF DEATH
(A) DUE TO
<u>Sepsis</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>20 days</u> | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) DUE TO
<u>Refractory Cancer</u> | | | <u>20 days</u> | | |
| | | | | | (C) <u>As CVD</u> | | | <u>year</u> | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (A) (this hospital) attended the deceased from <u>4-2</u> 19 <u>66</u> to <u>4-24</u> 19 <u>66</u> , that (B) (we) last saw the deceased alive on <u>4-24</u> 19 <u>66</u> and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE
<u>M. Zafarullah Khan</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
<u>4/24/66</u> | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>M. ZAFARULLAH KHAN</u> | | | | | 23D. ADDRESS
<u>City Hospital Baltimore</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4-28-66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Head of Christiana Cemetery - Newark, Delaware</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Ellsworth Armory - 4th Liberty Heights Ave</u> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 27 1966</u> | | 25B. NAME OF REGISTRAR
<u>R. E. S. S. S. S.</u> | | | 25C. FUNERAL DIRECTOR
<u>Ellsworth Armory</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|--|---|---|
| BIRTH NO. 66 04287 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04287 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Lucy WOODHULL PRESTI | | | 4-24-66 8:30 A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
ST. AGNES HOSPITAL | | | A. STATE MARYLAND
B. COUNTY 2008 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTO 29 | | |
| | | | D. STREET ADDRESS (If rural, give location)
115 SOUTH AUGUSTA AVE. | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
10-1-18 | 9. AGE (In years last birthday)
47 | 10. Under 1 Yr. Months Days
11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
CHARLES NELSON DEC'D | | | |
| 14. MOTHER'S MAIDEN NAME
Emma Blesche DEC'D | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO.
214-01-1040 | | 17. INFORMANT
WILKENS AVE. - #29 ST. AGNES HOSP. RECORDS - CATON & | | | |
| 18. 331X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ENCEPHALOMALACIA + BRAIN EDEMA | | | CAUSE OF DEATH
MASSIVE CEREBRAL HEMORRHAGE | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 22, 1966 to APRIL 24, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 24, 1966 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. | | | | | |
| 23A. SIGNATURE
Manfred F. Amrhein | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED |
| 23C. PHYSICIAN'S NAME (Type)
MANFRED F. AMRHEIN | | | 23D. ADDRESS
AVE. - BALTO. 29, MD. ST. AGNES HOSPITAL - CATON & WILKENS | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
April 27, 1966 | | 24C. NAME of CEMETERY or CREMATORY
Holy Redeemer Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Balto, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1966 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Fisher | | 25C. FUNERAL DIRECTOR
G. Truman Schwab 3512 Frederick Ave. Balto. | | | |

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10. 10. 10.

BIRTH NO.

66 04288

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES ADAMS

2. DATE AND HOUR PRONOUNCED DEAD

April 23, 1966 7:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Cecil

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Fort Deposit

D. STREET ADDRESS (If rural, give location)

Route 1

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

NEVER MARRIED

8. DATE OF BIRTH

8/10/1946

9. AGE (In years
last birthday)

19

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CARPENTERS HELPER

10B. KIND OF BUSINESS OR INDUSTRY

CONTRACTOR

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CARL T. ADAMS

14. MOTHER'S MAIDEN NAME

LORRAINE

RIALE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

2/17/64 - 8/19/64

16. SOCIAL
SECURITY NO.

220-42-6894

17. INFORMANT

ADDRESS

CARL T. ADAMS, PORT DEPOSIT, MD

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(A) Gunshot wound of head
DUE TO(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

farm

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Robert Rawlings Farm (Colona Cecil Co.)

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
April 22, '66 6:30P.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Accidentally shot self in head

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-23-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

4/26/1966

23C. NAME of CEMETERY or CREMATORY

NEW BRIDGE

23D. LOCATION

(City, town, or county)

COLONA

(State)

MD

24A. DATE REC'D BY HEALTH DEPT.

APR 27 1966

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Ralph M. Reed, Rising Sun, Md.

WALLISLEY FORDGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 66 04289 | |
|--|--|----------------------|--|--|--|---|--|---|--|--|--|
| KALANDROS | | | | | | | | | | 66 04289 | |
| CERTIFICATE OF DEATH | | | | | | | | | | X | |
| BIRTH NO. 66 04289 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ALMA KOLANDROS | | 2. DATE AND HOUR OF DEATH 4-25-66 | | 11:25 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 So. BALTO. GEN. HOSPITAL | | | | | | A. STATE Maryland B. COUNTY AA | | | | | |
| | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Glen Burnie 52-00 | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) 8 Hopkins Street | | | | | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | | 8. DATE OF BIRTH 7 April 1909 | | 9. AGE (In years last birthday) 57 | | If Under 1 Yr. Months: Days: (If Under 24 Hrs. Hours: Min.) | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress | | | | 10B. KIND OF BUSINESS OR INDUSTRY Restaurant | | 11. BIRTHPLACE (State or foreign country) West Virginia | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William James | | | | | | 14. MOTHER'S MAIDEN NAME Ethel L. Connors | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 213-18-0048 | | 17. INFORMANT ADDRESS Mrs Doris Boteler, 1002 Glenville, Glen Burnie, Md. | | | | | |
| 18. CAUSE OF DEATH | | | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | | |
| (A) ACUTE M.I. | | | | | | | | | | | |
| DUE TO | | | | | | | | | | | |
| (B) CHF | | | | | | | | | | | |
| DUE TO | | | | | | | | | | | |
| (C) CORONARY INFARCTION - OLD ? UNKNOWN | | | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 24 H | | | | | | | | | | | |
| II | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. OLD M.I. | | | | | | | | | | | |
| 30 DAYS | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this Hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Edward A. Hoffman M.D. | | | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 5/24/66 | |
| 23C. PHYSICIAN'S NAME (Type) Edward A. Hoffman | | | | | | 23D. ADDRESS M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 27 Apr. 66 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial | | | | 24D. LOCATION (City, town, or county) (State) Glen Burnie, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 27 1966 | | | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | | | 25C. FUNERAL DIRECTOR ADDRESS Kirkley Funeral Home, Glen Burnie, Md. | | | |

1145

ACCT MI

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General Information on

Old MI

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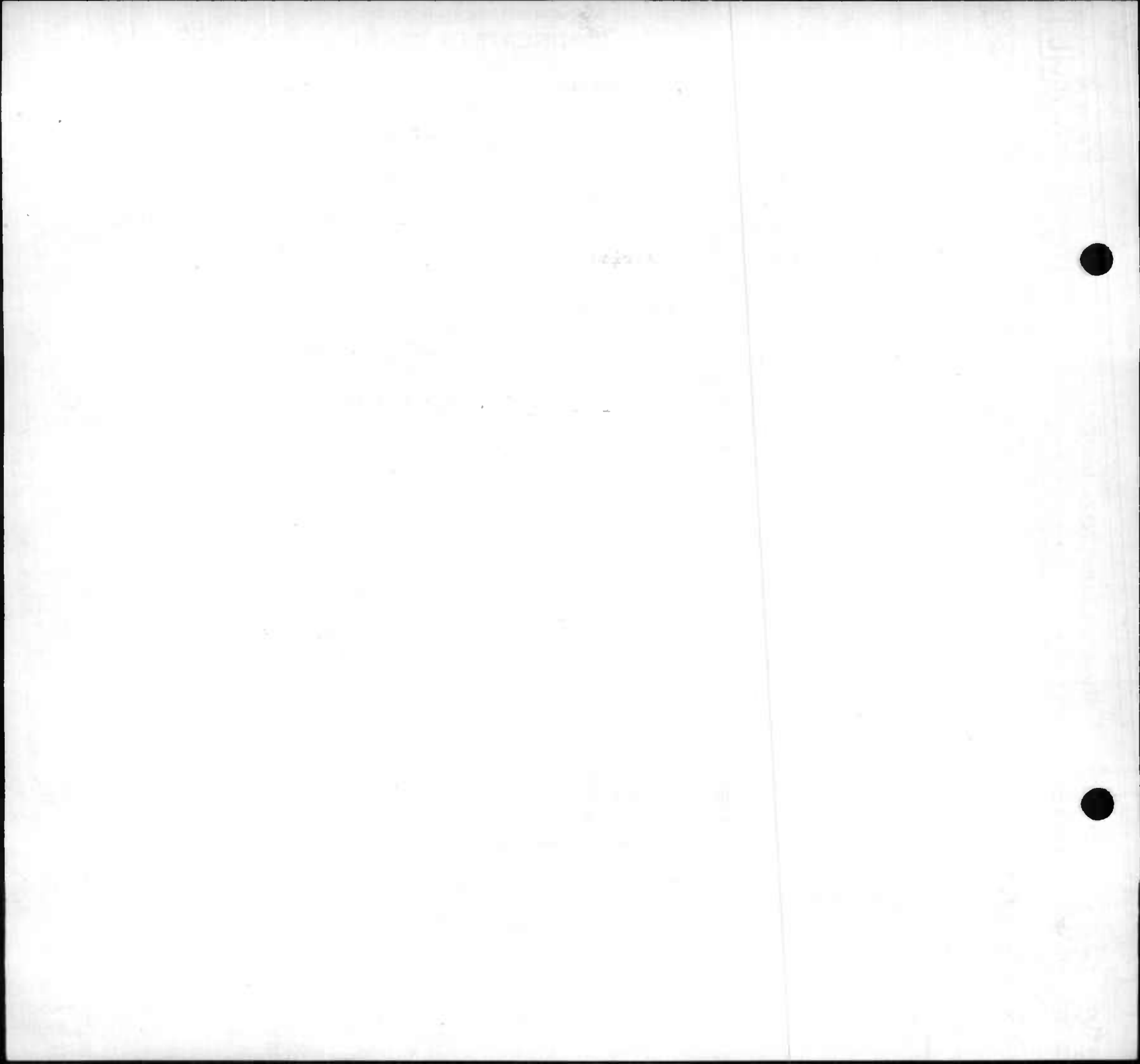
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Column A 11/1/45

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

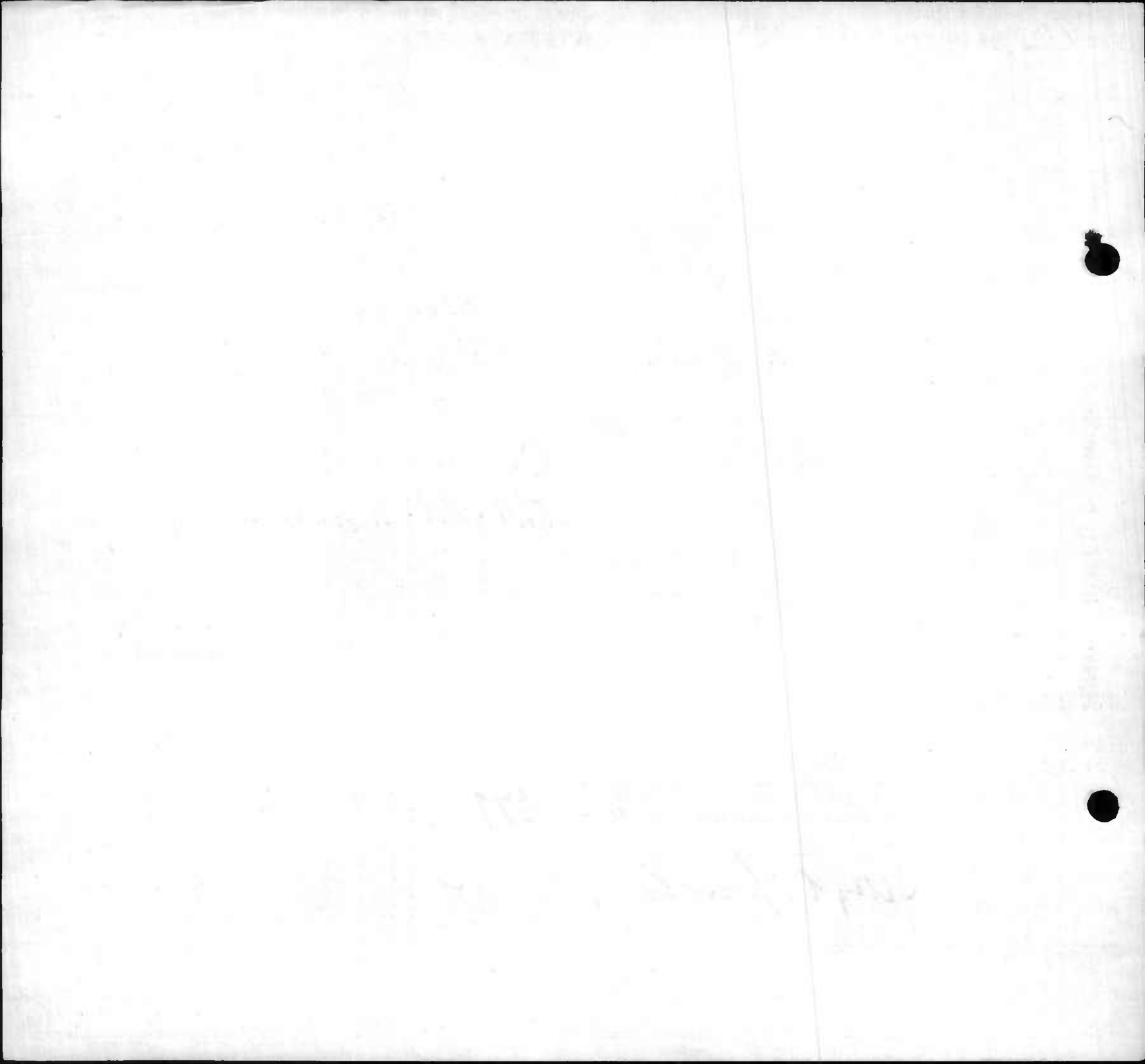
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04290 | |
|---|-------------------------|---|--|--|---|
| BIRTH NO. 66 04290 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Nellie B. Swartz | | | April 25, 1966 5⁰⁰ P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
5501 Roland Avenue
Baltimore, Maryland 21210 | | | A. STATE Maryland
B. COUNTY 27-13 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location)
5501 Roland Avenue 21210 | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
Dec. 6, 1897 | 9. AGE (In years last birthday)
68 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Chairman of the Board | | | 10B. KIND OF BUSINESS OR INDUSTRY
Farboil Paints | | 11. BIRTHPLACE (State or foreign country)
Ohio |
| 12. CITIZEN OF WHAT COUNTRY? | | | 13. FATHER'S NAME
Jermah Buckley | | |
| 14. MOTHER'S MAIDEN NAME
Lilly Lane | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No None | | |
| 16. SOCIAL SECURITY NO.
213-28-6981 | | | 17. INFORMANT ADDRESS
Mr. Charles Robins 2700 Ken Oak Road #15 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
491X I
Bronch-pneumonia | | | CAUSE OF DEATH
7 days | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO
(B) DUE TO
(C) DUE TO | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Parkinson's disease | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 1st 1965 to Apr 25 1966 , that (I) (we) last saw the deceased alive on Apr 25 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
William E. Helfrich M.D. | | | | 23B. DATE SIGNED
Apr 26, '66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/27/1966 | | 24C. NAME OF CEMETERY or CREMATORY
Hebrew Friendship Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1966 | | 25B. NAME OF REGISTRAR
Robert E. Fisher | | 25C. FUNERAL DIRECTOR
Wm. J. Fickner & Sons | |
| 25D. ADDRESS
Balto. Md. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

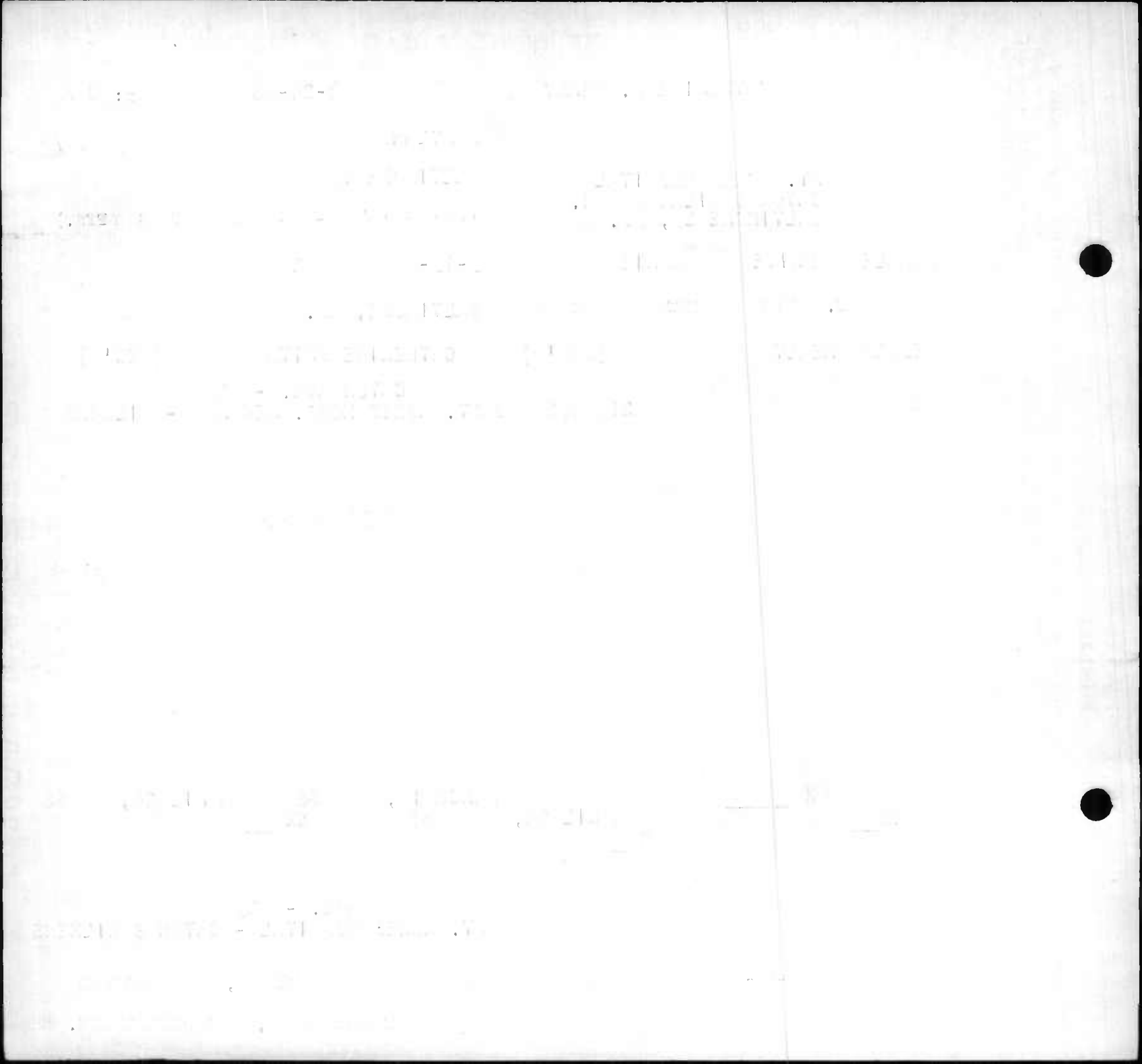
| | | | | | |
|--|-------------------------|--|-------------------------------------|--|---|
| BIRTH NO. 66 04291 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 66 04291 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) William H. Bailey | | 2. DATE AND HOUR OF DEATH
4/21/66 16:15 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
108 W. Montgomery St | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 22-01 | | | |
| | | D. STREET ADDRESS (If rural, give location)
108 W. Montgomery Street | | | |
| 5. SEX
M | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
11/23/98 | 9. AGE (In years last birthday)
67 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore Ma | |
| 13. FATHER'S NAME
William H. Bailey | | 14. MOTHER'S MAIDEN NAME
Rachel Wheatley | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Thelma B. Bailey ADDRESS 108 W. Montgomery St | |
| 18. I 141.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
Carcinoma of Tongue
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH
(A) DUE TO
Carcinoma of Tongue
(B) DUE TO
Chronic Bronchitis
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
18 hrs.
1 day | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 1964 to 4-21-1966 , that (I) (we) last saw the deceased alive on 4-21-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Jerry C. Luck | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4-21-66 | |
| 23C. PHYSICIAN'S NAME (Type)
JERRY C. LUCK | | 23D. ADDRESS
427 SWACE Rd. (25) | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4-25-66 | | 24C. NAME OF CEMETERY or CREMATORY
MOUNT CALVARY | |
| 24D. LOCATION (City, town, or county) (State)
ARUNDEL CO MD. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1966 | | 25B. NAME OF REGISTRAR
R. E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
J. L. Brown & Son ADDRESS 123 W. MONTGOMERY ST. | |



FUNERAL DIRECTOR: IMPORTANT

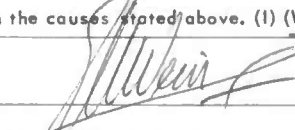
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

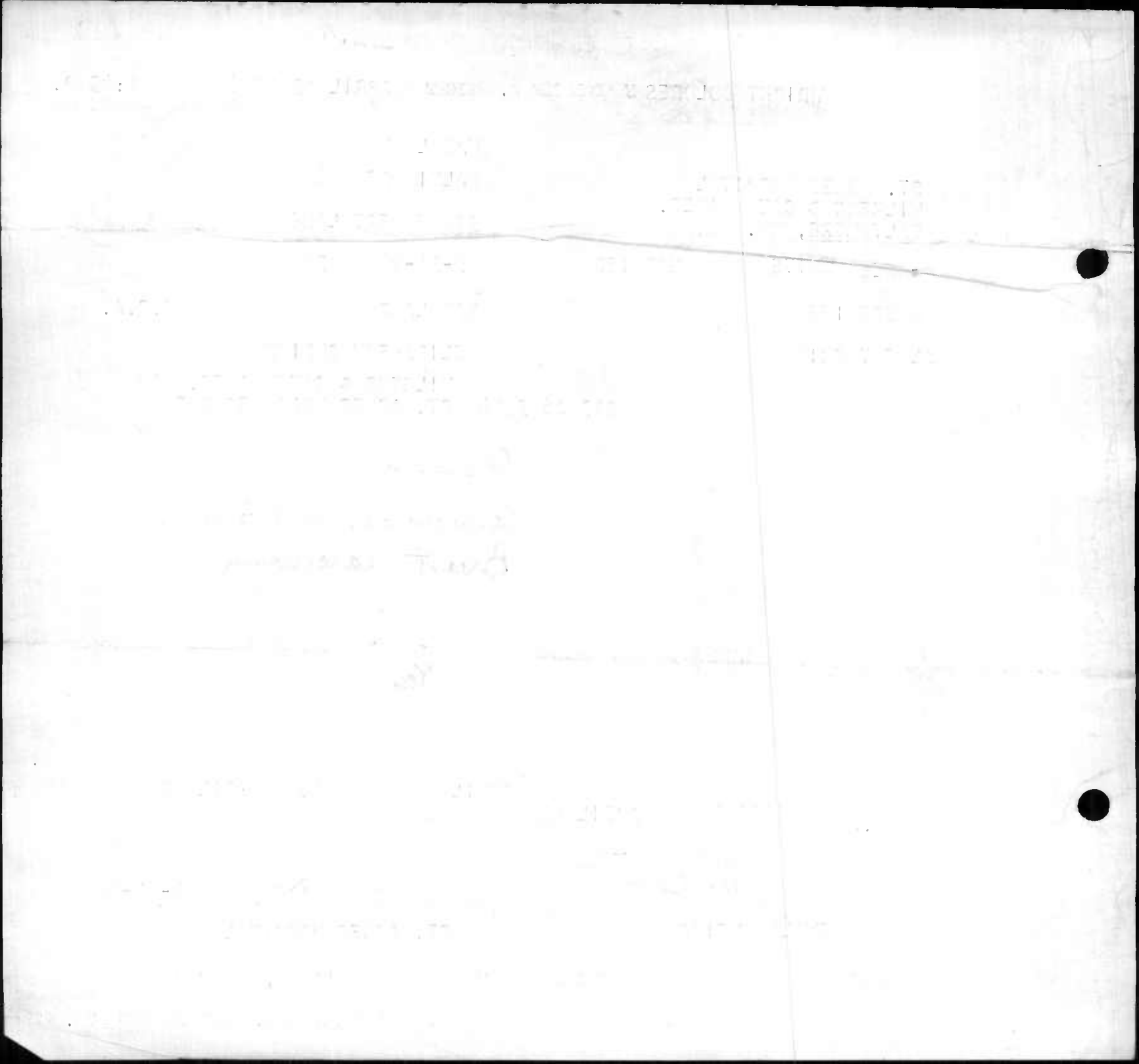
| | | | | | |
|--|------------------|--|-----------------------------|--|--|
| BIRTH NO. 66 04292 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04292 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) | | CATHERINE M. PERRY | | 2. DATE AND HOUR OF DEATH
4-24-66 9:50 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
MARYLAND | | 14-01 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
ST. AGNES HOSPITAL
CATON & WILKENS AVE.
BALTIMORE 29, MD. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 17 | | D. STREET ADDRESS (If rural, give location)
1701 EUTAW PLACE (MARLBOROUGH APTS.) | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
3-13-04 | 9. AGE (In years last birthday)
62 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
ASS'T. BUYER | | 10B. KIND OF BUSINESS OR INDUSTRY
HUTZLER BROTHERS | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MD. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
EDWARD HEALY (DEC'D) | | 14. MOTHER'S MAIDEN NAME
CATHERINE SMITH (DEC'D) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
215 072 606 | | 17. INFORMANT ADDRESS
CATON AVE. - #29
215 072 606 ST. AGNES HOSP. RECORDS - WILKENS & | |
| 18. 342X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) MENINGIOMA
DUE TO
(B) BRAIN ABSCESS
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (X) (this hospital) attended the deceased from MARCH 11, 19 66 to APRIL 24, 19 66, that (XX) (we) lost saw the deceased alive on APRIL 24, 19 66 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
Wenfredo N. Iglesias M.D. | |
| 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
AVE. - #29
ST. AGNES HOSPITAL - CATON & WILKENS M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4-27-66 | | 24C. NAME OF CEMETERY OR CREMATORY
LOUDON PARK CEMETERY | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1966 | | 25B. NAME OF REGISTRAR
R. E. F. F. F. | |
| 25C. FUNERAL DIRECTOR ADDRESS
HUBBARD FUNERAL HOME, 4107 WILKENS AVE. #29 | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | Registered No. 06 04293 | |
|--|--|--|--|--|--|--|--|
| BIRTH NO. 06 04293 | | | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. 06 04293 | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) WRIGHT DOLORES X DOLORES S. WRIGHT | | | | APRIL 23 1966 2:45 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. #29 | | | | A. STATE MARYLAND B. COUNTY Baltimore | | | |
| 5. SEX FEMALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | | | 8. DATE OF BIRTH 5-31-28 | | 9. AGE (In years last birthday) 37 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ALBERT SMITH | | | | 14. MOTHER'S MAIDEN NAME ELIZABETH SUDINA | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 213 26 5914 | | 17. INFORMATION WILKENS & CATON AVES. #29 | |
| 18. I 150X I | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) Cagueria | | | |
| (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | | | (B) Carcinomatous Metastasis | | | |
| ANTECEDENT CAUSES | | | | (C) Breast Carcinoma | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 6 19 66 to APRIL 23 19 66 , that (I) (we) last saw the deceased alive on APRIL 23 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE  | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 4-23-66 | |
| 23C. PHYSICIAN'S NAME (Type) EWALDO WEISS | | | | 23D. ADDRESS ST. AGNES HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 4-26-66 | | 24C. NAME OF CEMETERY or CREMATORY LOUDON PARK CEMETERY | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 27 1966 | | 25B. NAME OF REGISTRAR R. E. Fairley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS HUBBARD FUNERAL HOME, 4107 WILKENS AVE. #29 | | | |

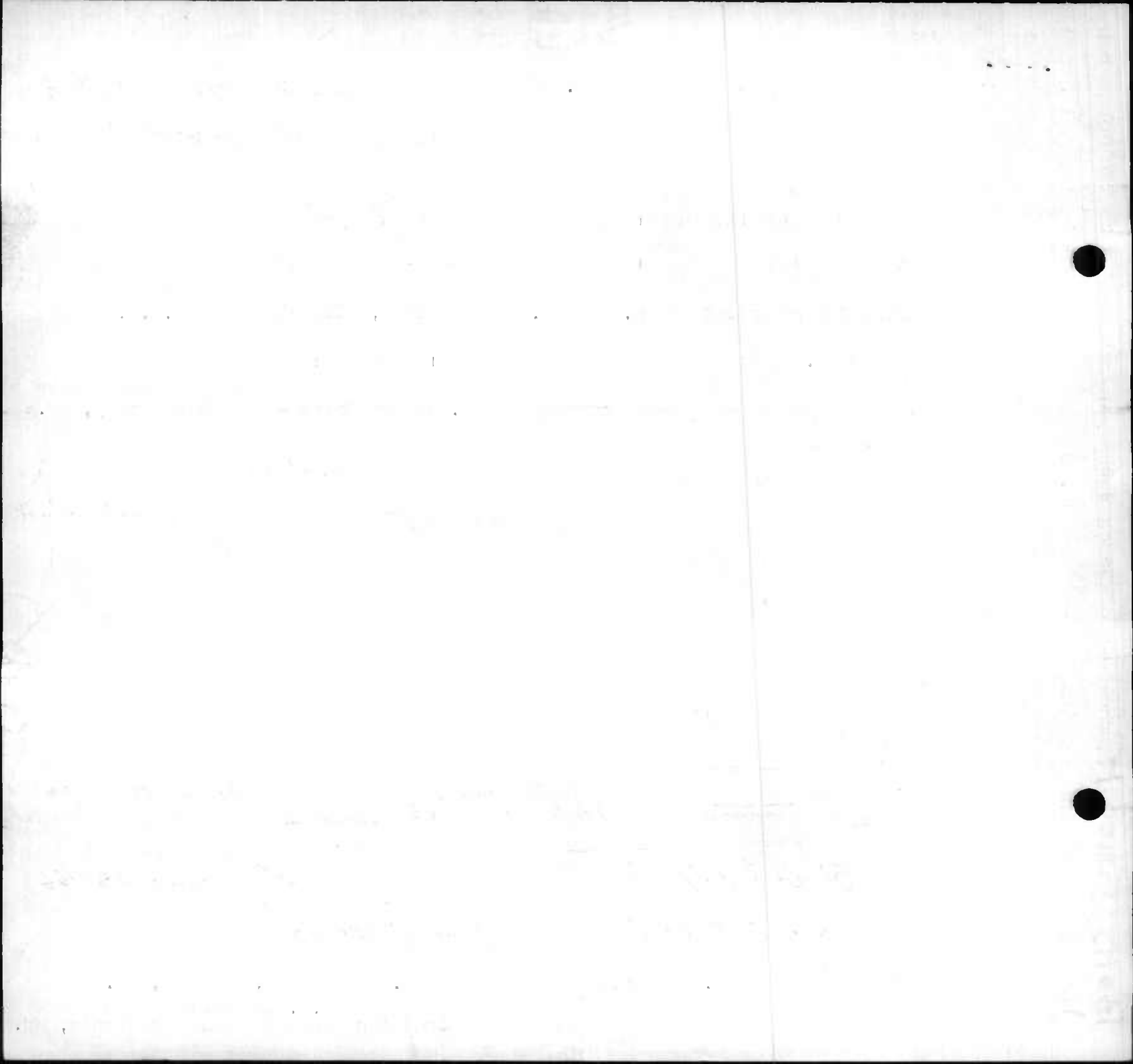


Botts James H. The body of James Botts was released to The Johns Hopkins Hospital non-med by Dr. Grayson of the Medical Examiners. This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

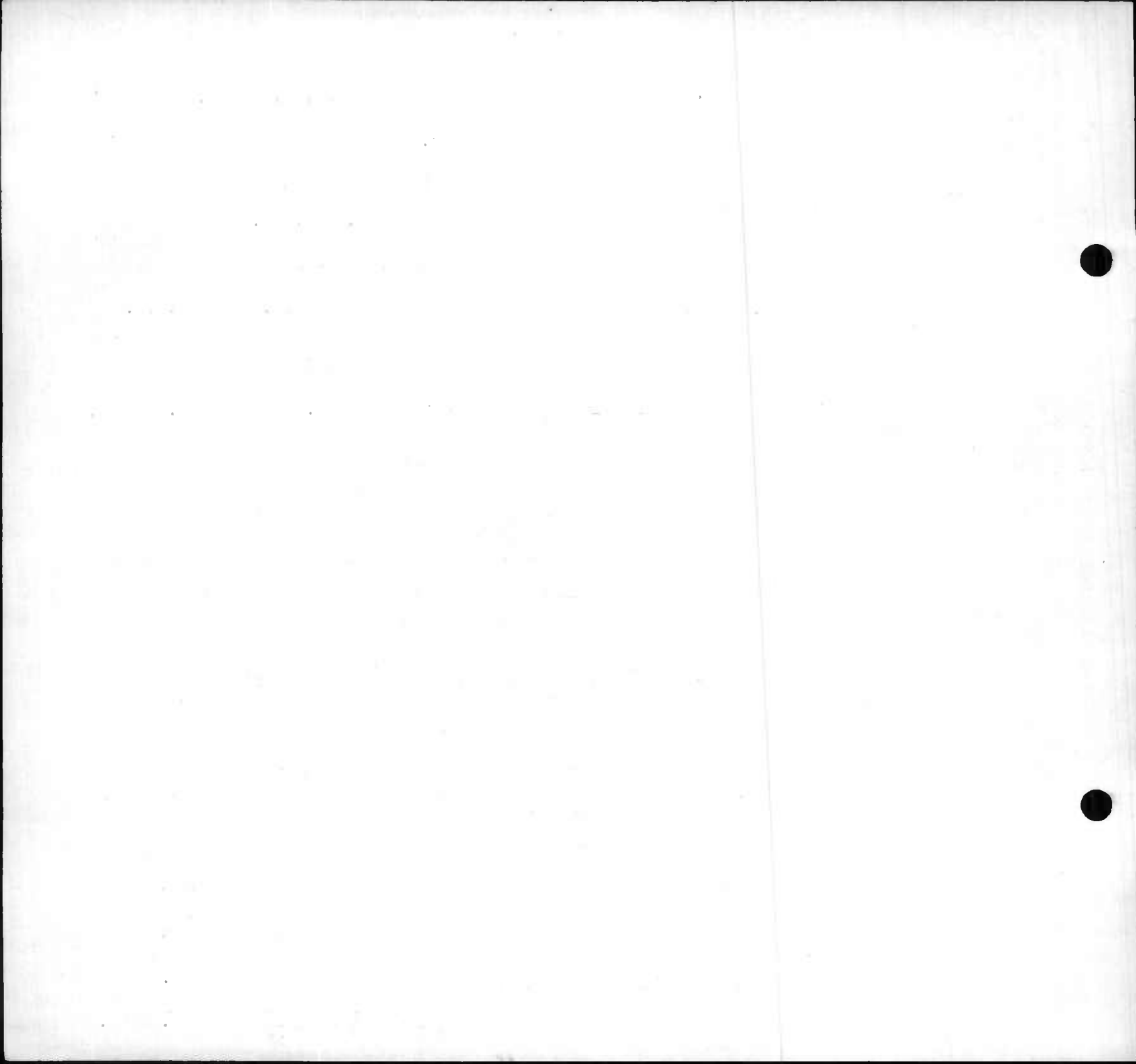
| | | | | | |
|--|-------------------------|---|-------------------------------------|---|--|
| BIRTH NO. 13320 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04294 | |
| M.E. CASE NO. 66 04294 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) JAMES BOTTS Sr. | | 2. DATE AND HOUR OF DEATH
April 25, 1966 12 40 A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give sheet address or location)
THE JOHNS HOPKINS HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
ODENTON
D. STREET ADDRESS (If rural, give location)
RT #1 Box 354 | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
12-28-89 | 9. AGE (In years last birthday)
76 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Railroad Foreman(ret) Penn. R/R Co. | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Fairfax, Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
MICHAEL C. BOTTS | | | |
| 14. MOTHER'S MAIDEN NAME
BRIDGET HAMILTON | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | |
| 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
Mr. Norman Botts - | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Sudden Asystole
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
HAS CVD
INTERVAL BETWEEN ONSET AND DEATH
indeterminate | | 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
May 19 1965 | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 19 1965 to April 19 1966 that (I) (we) last saw the deceased alive on April 19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Robert R. Keut | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
April 25, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
Robert R. Keut | | 23D. ADDRESS
M.D. Johns Hopkins | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
28 Apr. 66 | | 24C. NAME OF CEMETERY or CREMATORY
Trinity Methodist Ch Cem. | |
| 24D. LOCATION
Patuxant, Odenton, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1966 | | | |
| 25B. NAME OF REGISTRAR
R. E. Feltner | | 25C. FUNERAL DIRECTOR
R. V. Singleton | | | |
| 25D. ADDRESS
Singleton Funeral Home/Glen Burnie, Md. | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

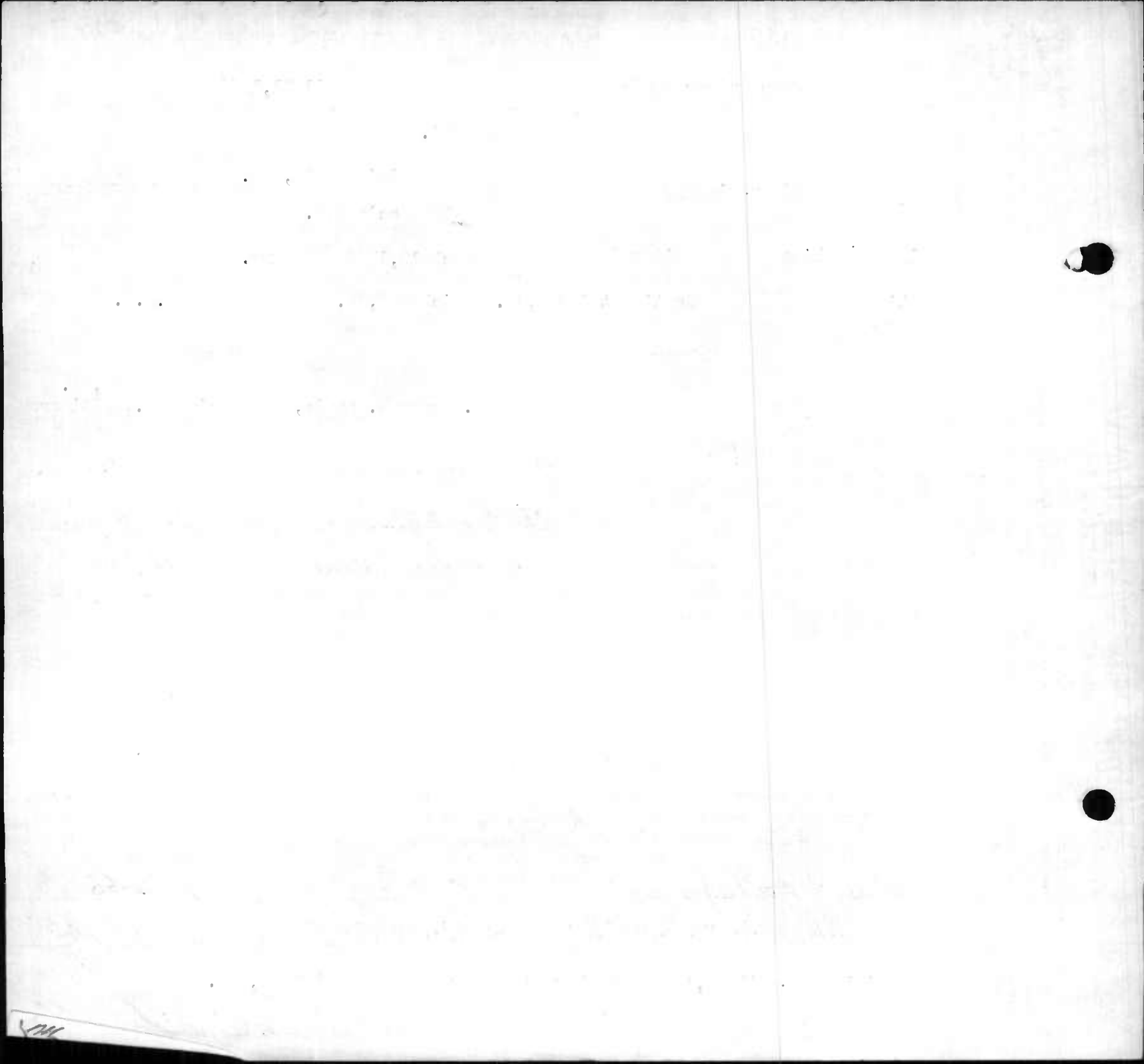
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>66 04295</u> | |
|--|--------------|--|-------------------------|---|--|--|--|
| BIRTH NO. <u>66 04295</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | <u>Viola K. Timmons</u> | | <u>April, 25, 1966</u> <u>9.55 A.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| <u>Union Memorial Hospital</u> | | | | <u>Md.</u> <u>1306</u> | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | <u>Baltimore</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | <u>1114 W. 36th. St.</u> | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. 11. Under 24 Hrs. Months Days Hours Min. | | |
| <u>Female</u> | <u>White</u> | <u>Widowed</u> | <u>Oct, 20, 1892-73</u> | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>House Wife</u> | | | | <u>Washington, D.C.</u> | | <u>U.S.A.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Luther Eckert</u> | | | | <u>Katie Walford</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| <u>no</u> | | <u>213- 28-2224</u> | | <u>Roland Timmons</u> | | <u>522 Church St. 21225</u> | |
| 18. <u>4-20-11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| <u>0</u> | | | | <u>Yes</u> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| <u>Yes</u> | | <u>Yes</u> | | <u>Yes</u> | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| <u>Yes</u> | | <u>While At Work</u> | | <u>Yes</u> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4-10-66</u> to <u>4-25-66</u> 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>4-10-66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| <u>James G. Saffell</u> M.D. | | | | <u>4-26-66</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| <u>James G. Saffell</u> M.D. | | | | <u>Beustown</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>4/28, 1966</u> | | <u>St. Marys (Hampden)</u> | | <u>Baltimore Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| <u>APR 27 1966</u> | | <u>Robert E. Taylor</u> M.D. | | <u>Frank X. Scitz</u> | | <u>814 W. 36th. S</u> | |



FUNERAL DIRECTOR: IMPORTANT

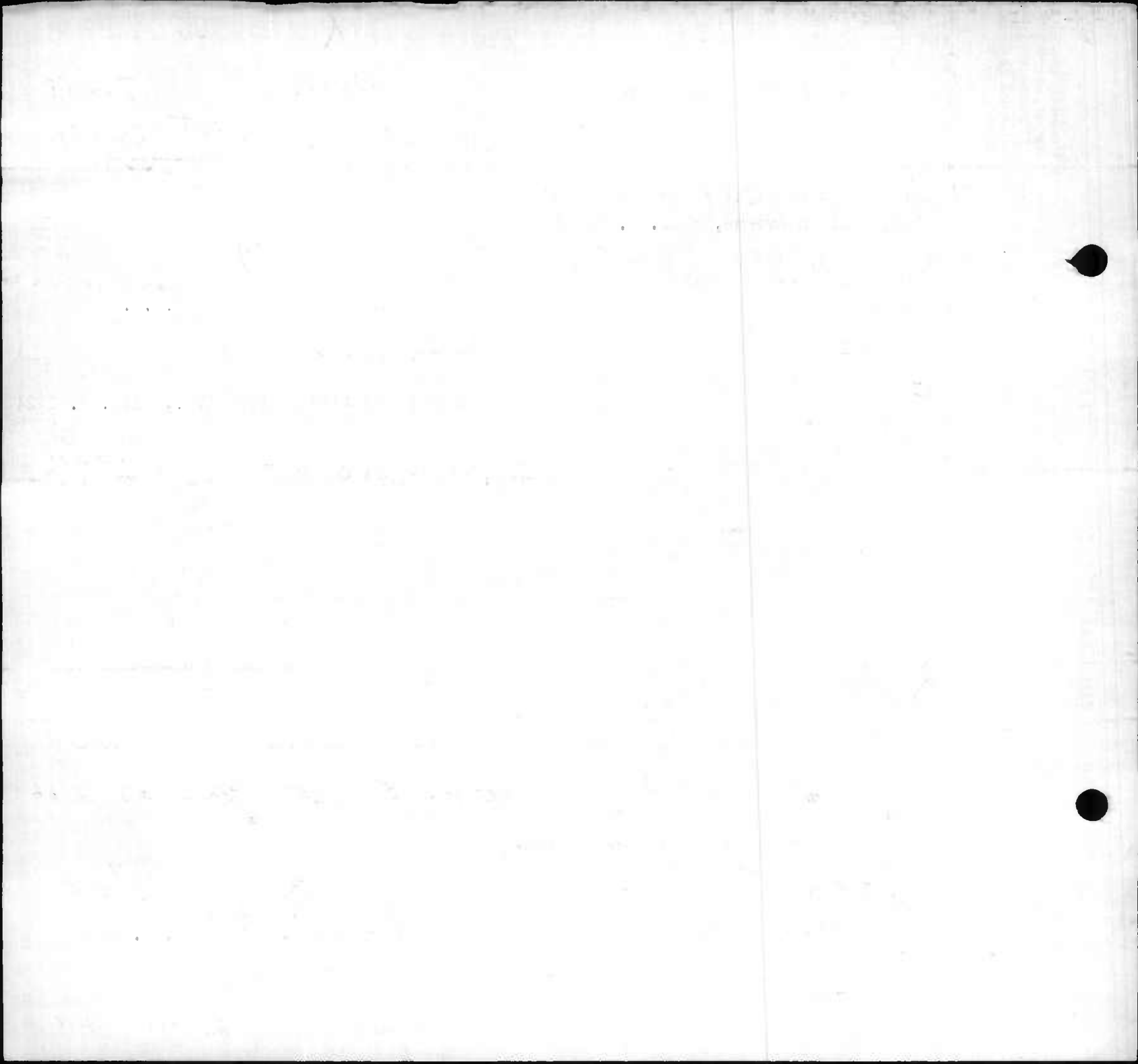
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04296 | |
|---|---|---|--|---|---|
| BIRTH NO. 66 04296 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) John Andrew Meads | | | | April 21, 1966 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
Hood Nursing Home | | | | A. STATE Md.
B. COUNTY | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 29, Md. 25-31 | |
| | | | | D. STREET ADDRESS (If rural, give location)
639 Lucia Ave. | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
March 12, 1880 | 9. AGE (In years last birthday)
86 yrs. | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY
Continental Can. Co. | | 11. BIRTHPLACE (State or foreign country)
Richmond, Va. |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 13. FATHER'S NAME
Unknown | | |
| 14. MOTHER'S MAIDEN NAME
Unknown | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No None | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS
Mr. Norman E. Meads, 639 Lucia Ave., Baltimore 29, Md. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Acute Pneumonia | | | CAUSE OF DEATH
(A) Acute Pneumonia
DUE TO | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | (B) Chr. Emphysema
DUE TO | | |
| | | | (C) Chr. Myocarditis
DUE TO | | |
| INTERVAL BETWEEN ONSET AND DEATH
2 ds. | | | 10-15 yrs. | | |
| 10 yrs. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-27-1963 to 4-21-1966 , that (I) (we) lost saw the deceased alive on 4-21-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Wilmer R. Gallagher, Jr. | | | | 23B. DATE SIGNED
4-23-66 | |
| 23C. PHYSICIAN'S NAME (Type)
Wilmer R. Gallagher, Sr. | | | | 23D. ADDRESS
6209 Frederick Ave Baltimore 28 Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
April 25, 1966 | | 24C. NAME OF CEMETERY or CREMATORY
Woodlawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Woodlawn, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1966 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
Frank H. Newell, Pikesville, Md. | | 25D. ADDRESS
Pikesville, Md. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 04297 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04297 | |
|---|--|----------------------------------|--|-------------------------|--|
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) IRVING COOK | | | 4/20/66 7:25 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| BALTIMORE CITY HOSPITALS
4940 Eastern Avenue, Balto, Md. 21224 | | | MARYLAND CALVERT COUNTY | | |
| 5. SEX 6. RACE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| MALE NEGRO MARRIED | | | Rt. 306 54-00 | | |
| 8. DATE OF BIRTH 9. AGE (In years last birthday) | | | D. STREET ADDRESS (If rural, give location) | | |
| 7-4-06 59 | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | |
| Farmer | | | MARYLAND | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| | | | U.S.A. | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| WARNIE | | | ANNIE Louis | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes () or unknown ()) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| | | | 218-12-9437 | | |
| 17. INFORMANT | | | ADDRESS | | |
| RECORDS: BCH 4940 Eastern Ave., Balto, Md. 21224 | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | 1 YEAR | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | |
| 2/21/66 INTRACTABLE PAIN | | | Yes | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED | | |
| | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 22. I certify that (this hospital) attended the deceased from OCTOBER 25 19 65 to APRIL 20 19 66, that (we) last saw the deceased alive on APRIL 20 19 66 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (view) the body after death. | | | 21F. HOW DID INJURY OCCUR? | | |
| 23A. SIGNATURE | | | 23B. DATE SIGNED | | |
| James T. Sparks M.D. | | | 4/20/66 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| JAMES T. SPARKS | | | Baltimore City Hospitals | | |
| | | | 4940 Eastern Avenue, Baltimore, Md. 21224 | | |
| 24A. BURNAL CREMATION, REMOVAL (Specify) | | | 24B. DATE | | |
| | | | 4-25-66 | | |
| 24C. NAME OF CEMETERY or CREMATORY | | | 24D. LOCATION (City, town, or county) (State) | | |
| Mt. Hope Ch. Cem. | | | Sunderland Md | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR | | |
| APR 27 1966 | | | Robert E. Taylor, M.D. | | |
| 25C. FUNERAL DIRECTOR | | | ADDRESS | | |
| Pinkney E. Sewell - Pa. Fred - mcl | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66-04298 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 86 114298 | |
|--|---------|--|------------------|---|--|--|------------------------------|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | Elizabeth E. Austin | | 4-25-1966 2:30 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE Md. | | B. COUNTY Baltimore | |
| 2709 Lactona Road #14 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location) | | 2709 Lactona Road #34 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| Female | White | Single | 5-3-1878 | 87 | Housewife | Littlefalls, W.Va. | U.S.A. |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Eldridge Austin | | | | Josephine Tichnel | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | None | | Mr William G. Neary 2709 Lactona Road #14 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | Central Saccular | | 2 months | |
| | | | | accident | | | |
| ANTECEDENT CAUSES | | | | (A) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | Central | | 5 years | |
| | | | | (B) DUE TO | | | |
| | | | | arteriosclerosis | | | |
| | | | | (C) DUE TO | | | |
| | | | | arteriosclerosis | | 10 years | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 2 1966 to April 25 1966, that (I) (we) last saw the deceased alive on April 25 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| George Sawyer M.D. | | | | 4/26/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| GEORGE SAWYER M.D. | | | | 4808 Harford Rd. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 4-28-1966 | | Pisgah Cemetery | | Morganstown W. Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS (34) | |
| APR 27 1966 P.E. | | G.E. Feltner | | Lassah Funeral Home | | 5401 Belair Rd. | |

None

5
Cultural 1/2
Weekend
Cultural
Cultural
Cultural
Cultural

1
G 435

| BALTIMORE CITY HEALTH DEPARTMENT | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. 66 04299 | |
|---|------------------|---|---|---|--|---|--|
| BIRTH NO. 66 04299 | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) Robert GLADDEN Sr. | | | | 2. DATE AND HOUR PRONOUNCED DEAD
4/23/66 7.50 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

St. Agnes Hosp. (DOA) | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Ellicott City
D. STREET ADDRESS (If rural, give location)
16 Dartmouth Rd. | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
May 29, 1898 | 9. AGE (In years last birthday)
67 | 10. If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Balto. Gas & Electric Co. Ret. | | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
Abel Durham Gladden | | | 14. MOTHER'S MAIDEN NAME
Ella Miller | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
Yes W.W.I | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS
Margaret E. Gladden | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 4-24-66 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
4-27-66 | 23C. NAME OF CEMETERY or CREMATORY
Loudon Park | | 23D. LOCATION (City, town, or county) (State)
Baltimore Md. | | |
| 24A. DATE REC'D BY HEALTH DEPT.
APR 27 1966 | | 24B. NAME OF REGISTRAR
E. S. MacNabb | | 24C. FUNERAL DIRECTOR ADDRESS
E. S. MacNabb 301 Frederick Rd. 21228 | | | |

MAIL ROOM

No. 1

1

Belmont

London Park

10-10

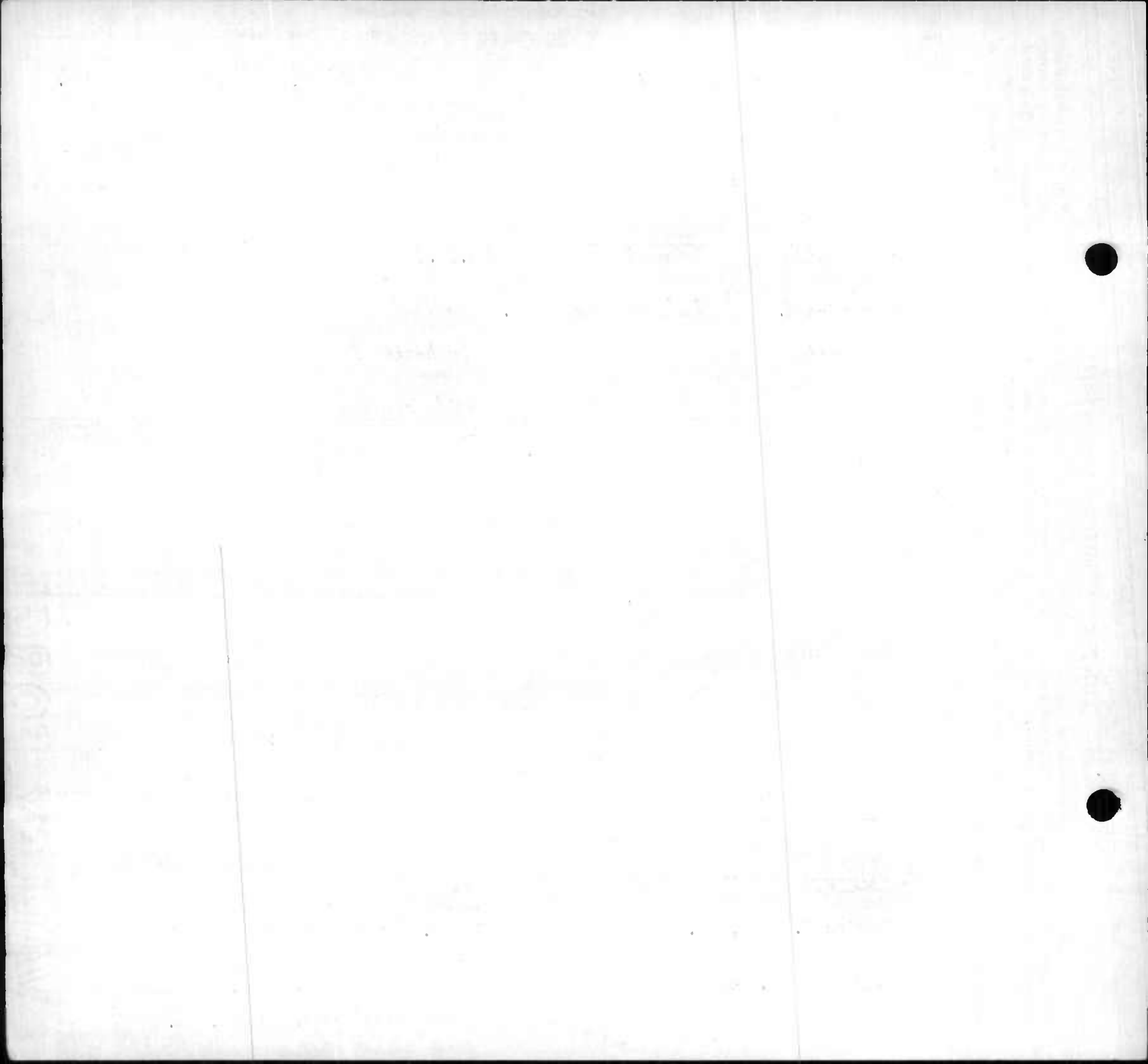
10-10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 04300 | |
|---|-------------------------|---|--|--|---|--|--|
| BIRTH NO. 66 04300 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Jacques Lelie | | 2. DATE AND HOUR OF DEATH
April 23, 1966 4 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
6208 The Alameda | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY 27-38
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
6208 the Alameda | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
Oct. 18, 1889 | 9. AGE (In years, lost birthday)
74 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Lumber Agent-ret. | | 10B. KIND OF BUSINESS OR INDUSTRY
Wholesale Lumber Co. | | 11. BIRTHPLACE (State or foreign country)
Holland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Joseph Lelie | | | | 14. MOTHER'S MAIDEN NAME
Catherine ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Family records | | ADDRESS | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Coronary Occlusion
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Atherosclerosis | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 13 19 53 to April 23 19 66 , that (I) (we) last saw the deceased alive on April 10 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Charles E. Carr, Jr. | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/25/66 | |
| 23C. PHYSICIAN'S NAME (Type)
Charles E. Carr, Jr. | | | | 23D. ADDRESS
M.D. 3900 N. Charles Street 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Cremation | | 24B. DATE
Apr. 25, 1966 | | 24C. NAME OF CEMETERY or CREMATORY
Greenmount Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1966 | | 25B. NAME OF REGISTRAR
R. E. Farley, M.D. | | 25C. FUNERAL DIRECTOR
John Burns' Sons, Towson, Md. | | | |

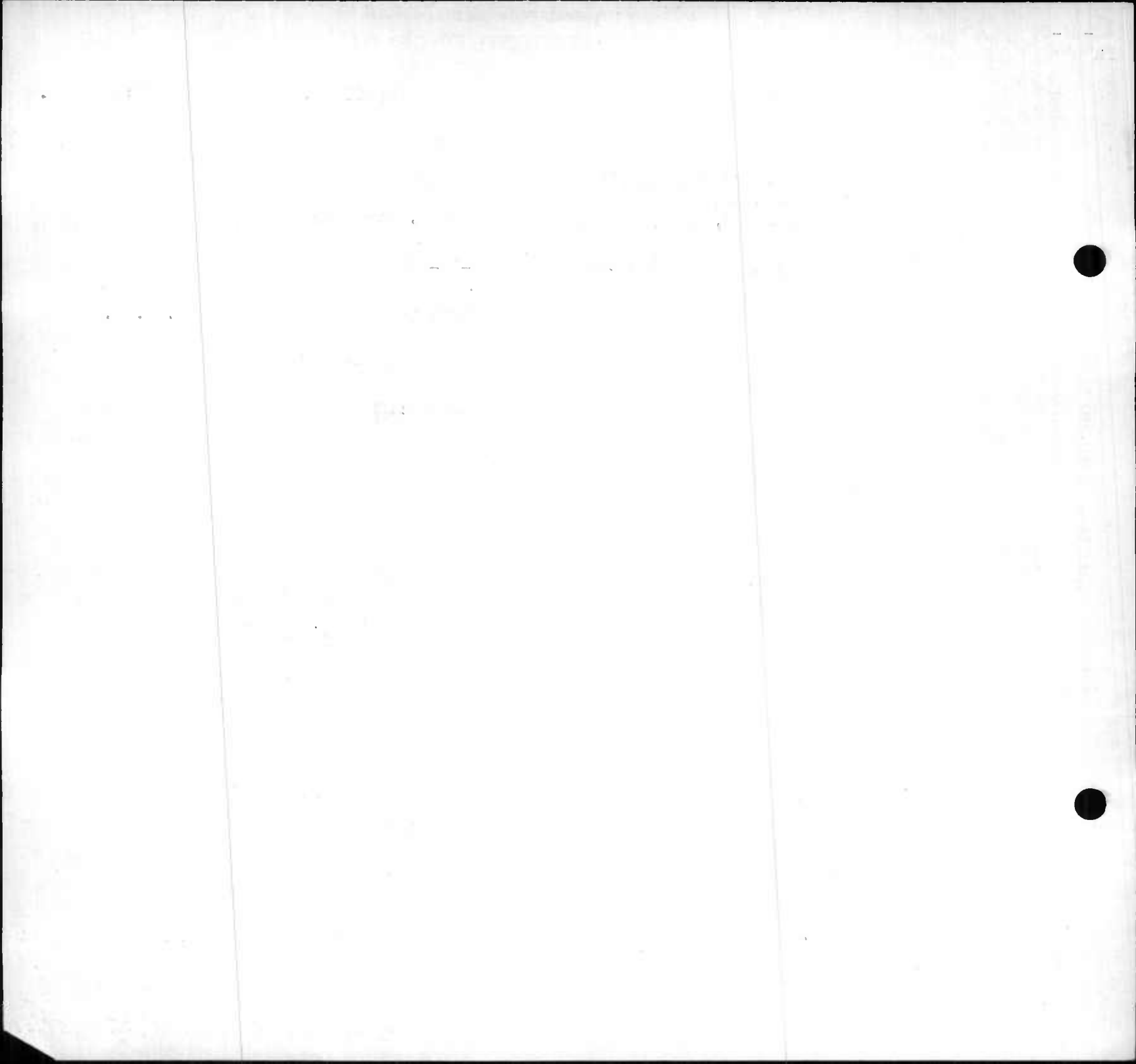


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04301 | |
|--|-------------------------|---|---|--|---|
| BIRTH NO. 66 04301 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print)
Theodore Turek | | | 2. DATE AND HOUR OF DEATH
April 21, 1966 10:45 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

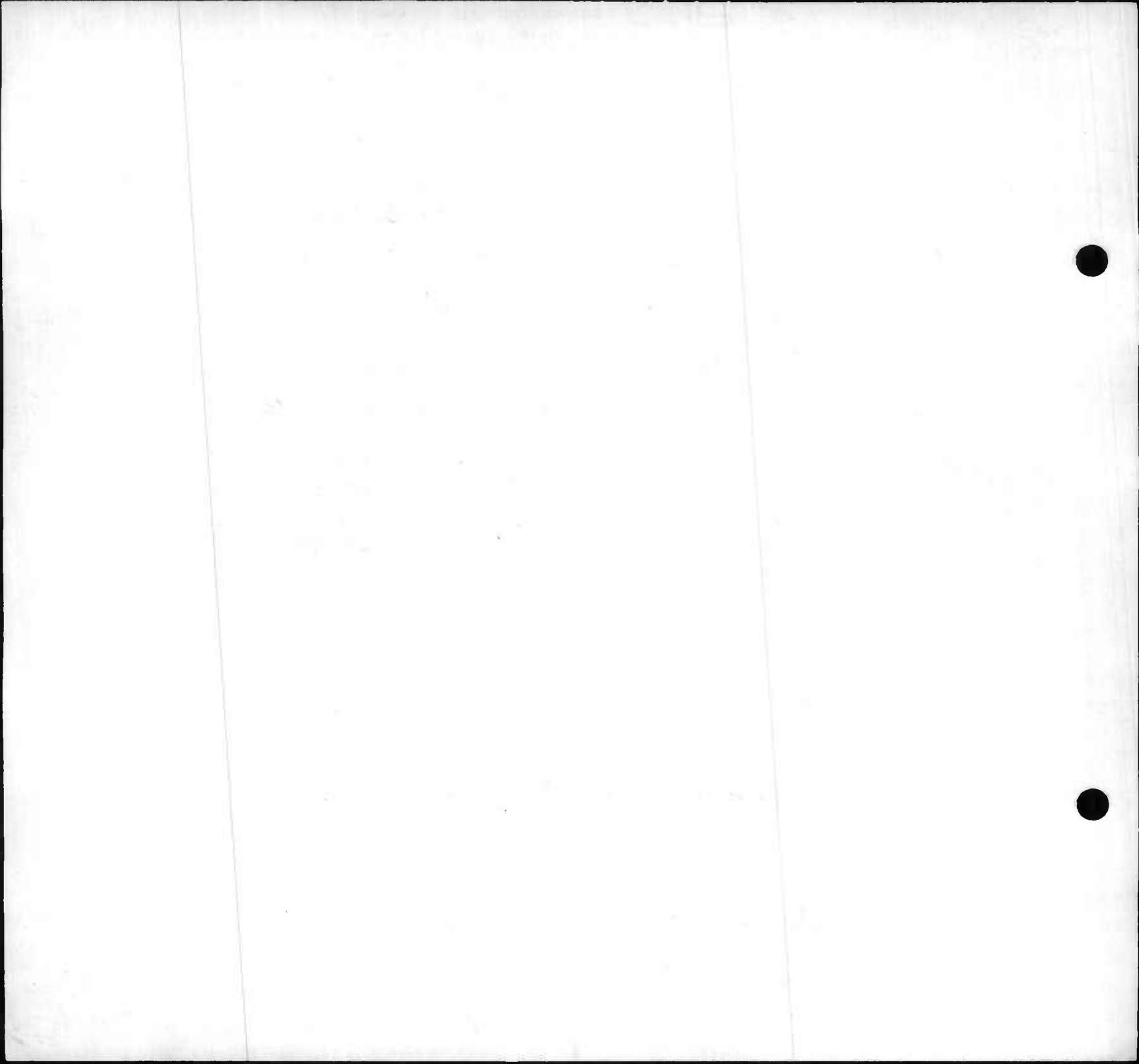
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY 1-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
525 S. Port Street 21224 | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Divorced | 8. DATE OF BIRTH
4-21-96 | 9. AGE (In years last birthday)
70 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | 13. FATHER'S NAME
LUKE TUREK | | |
| 14. MOTHER'S MAIDEN NAME
MARY GULBAN | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS
RECORDS: BCM 4940 Eastern Avenue 21224 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
420.1 L 156.1
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
MI | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO
(B) DUE TO
(C) DUE TO | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
CA of the Liver | | | | | |
| 21A. DATE OF OPERATION | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 21, 1966 to April 21, 1966 , that (I) (we) last saw the deceased alive on April 21, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Dr. Joel Richmon M.D. | | | | 23B. DATE SIGNED
4-21-66 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Joel Richmon M.D. | | | | 23D. ADDRESS
4940 Eastern Avenue Baltimore, Maryland 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4-25-1966 | | 24C. NAME OF CEMETERY OR CREMATORY
HOLY ROSARY CEMETERY BALTIMORE C. MD. | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE C. MD. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1966 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
RAYMOND L. KACZOROWSKI | | 25D. ADDRESS
2525 F... | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 66 04302 | |
|---|-------------------------|--|--------------------------------------|---|--|--|---|
| BIRTH NO. 66 04302 | | M.E. CASE NO. 66 04302 | | 1. NAME OF DECEASED
(Type or Print) WERONIKA BOGDANOWICZ (BOGDAN) | | 2. DATE AND HOUR OF DEATH
4-23-66 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 1-04 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
834 S. KENWOOD AVE. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
834 S. KENWOOD AVE. | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
11-7-1884 | 9. AGE (In years last birthday)
81 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
POLAND | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. |
| 13. FATHER'S NAME
MARTIN ANDRZEJEWski | | | | 14. MOTHER'S MAIDEN NAME
BARBARA | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO.
213-18-1520 | | 17. INFORMANT
MISS BARBARA BOGDANOWICZ
ADDRESS 834 S. KENWOOD AVE. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
446X I
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) Cerebro-vascular accident
DUE TO Myocardial Hypertension?
(B) Senile Arterio-sclerosis
DUE TO Ch. vascular Heart Disease?
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 1963 to April 23 1966 , that (I) (we) last saw the deceased alive on April 23 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
I. J. FEINGLOS | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/25/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
2007 E. PRATT ST. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4-28-66 | | 24C. NAME OF CEMETERY or CREMATORY
HOLY ROSARY CEMETERY | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE COUNTY MD. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1966 | | 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR
HOFFMANN FUNERAL HOME | | ADDRESS
3218 HUDSON ST. | |



K 520¹

66 04303

BALTIMORE CITY HEALTH DEPARTMENT

66 04303

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH KANIECKI

2. DATE AND HOUR PRONOUNCED DEAD

April 22, 1966 8:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

CHURCH HOME AND HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

703 S. Lakewood Ave.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

3-14-1910

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

PROSSEROR

10B. KIND OF BUSINESS OR INDUSTRY

H.T. LANGRALL CO.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

MICHAEL

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

217-01-4179

17. INFORMANT

ADDRESS

MRS. CLARA KANIECKI 703 S. LAKEWOOD AVE

18.

E900.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cranio-cerebral injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

703 S Lakewood Ave.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
4-22-66 7:30 P.m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Apparently fell down stairs

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
4-23-6623A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4-27-1966

23C. NAME OF CEMETERY or CREMATORY

ST. STANISLAUS CEMETERY

23D. LOCATION

BALTIMORE

(City, town, or county)

(State)

MD.

24A. DATE REC'D BY HEALTH DEPT.

APR 27 1966

24B. NAME OF REGISTRAR

E. E. E.

24C. FUNERAL DIRECTOR

RAYMOND L. KACZOROWSKI 2525 FLEET ST.

ADDRESS

MAINTENANCE

PRO. CONTINUED

11/1/71

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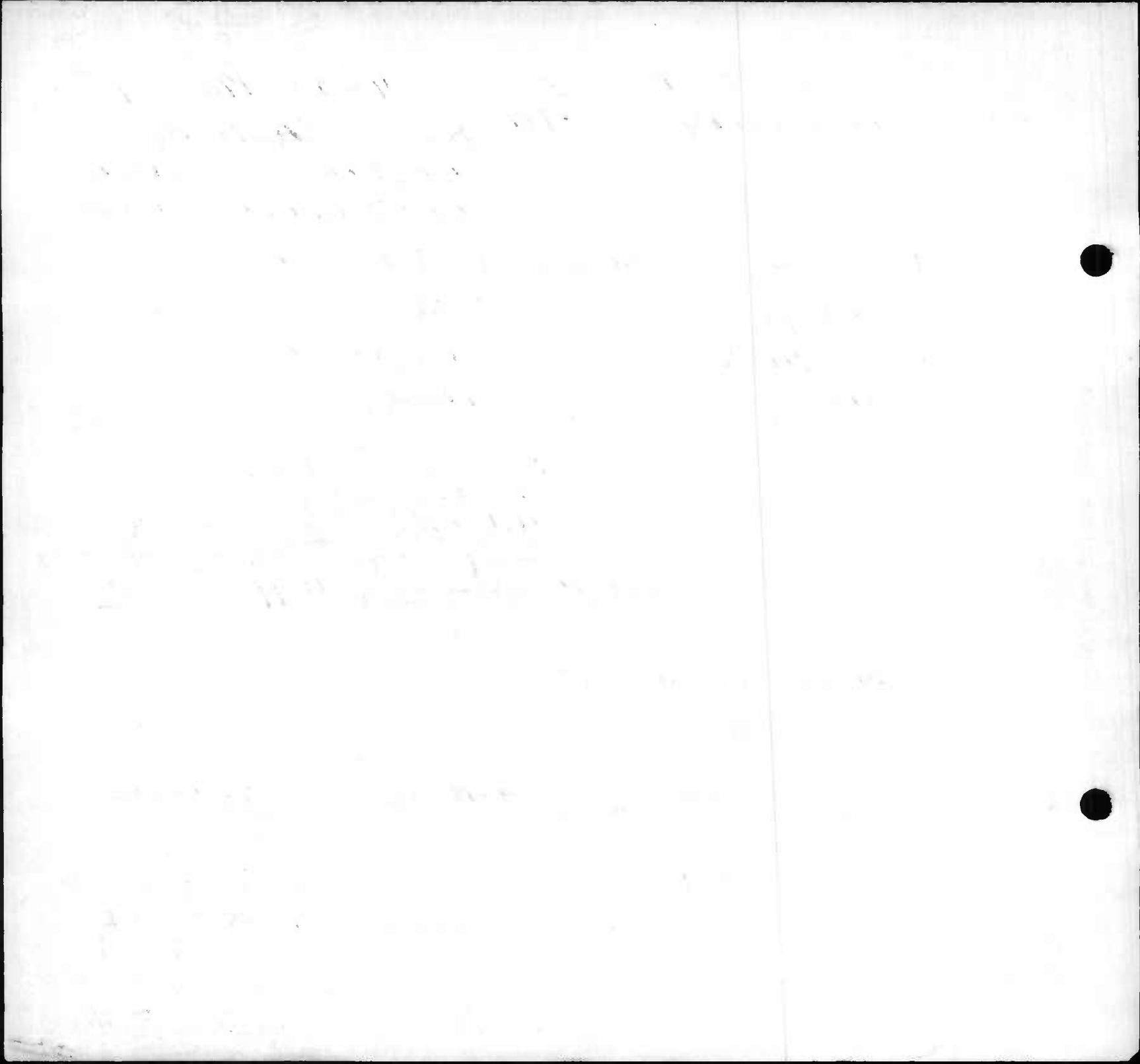
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11/1/71

11/1/71

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|---|--|---------------------|--|--|--|------------------------------------|--|--|--|--|--|-------------------------------|--|--|
| BIRTH NO. 66 04304 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 04304 | | | | |
| 1. NAME OF DECEASED
(Type or Print) ELNORA BOSSE | | | | | 2. DATE AND HOUR OF DEATH
4-22-1966 1⁰⁰ P. M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
UNIVERSITY HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD. B. COUNTY BALTO. CO. | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 2122 | | | | | 53-10 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
6823 Belclare Road | | | | | | | | | |
| 5. SEX
F | | 6. RACE
W | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
1-29-15 | | 9. AGE (In years last birthday)
51 | | 10. Under 1 Yr. Months: Days | | 11. Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
— | | | | | 11. BIRTHPLACE (State or foreign country)
MD. | | | | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. | | | | | 13. FATHER'S NAME
Henry McNew | | | | | 14. MOTHER'S MAIDEN NAME
Margaret Frass | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | | 16. SOCIAL SECURITY NO.
214-03-2571 | | | | | 17. INFORMANT
Chart MR. MICHAEL BOSSE | | | | |
| | | | | | ADDRESS
6823 BELCLARE RD | | | | | | | | | |
| 18. 410X I | | | | | | | | | | CAUSE OF DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | (A) Heart failure postop. cardiac surgery for | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | (B) Mitral Stenosis, pulmonary insufficiency, Tricuspid insufficiency | | | | |
| | | | | | | | | | | (C) Severe pulmonary Hypertension | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION
4-19-66 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Severe Mitral Stenosis | | | | | 20A. AUTOPSY? (Yes or No) | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
NO | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
— | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
NO | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR?
— | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-19-66 19 to 4-22-66 19, that (I) (we) last saw the deceased alive on 4-22-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE
Dr. J. A. Adler | | | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | |
| 23B. DATE SIGNED
4-22-66 | | | | | | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. FRAZ A. ADLER | | | | | | | | | | 23D. ADDRESS
UNIVERSITY HOSPITAL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | | | 24B. DATE
4-26-66 | | | | | 24C. NAME OF CEMETERY OR CREMATORY
OAKLAWN CEMETERY | | | | |
| | | | | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE COUNTY MD. | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1966 | | | | | 25B. NAME OF REGISTRAR
Robert E. Fisher | | | | | 25C. FUNERAL DIRECTOR
HOFFMANN FUNERAL HOME | | | | |
| | | | | | ADDRESS
3218 HUDSON ST. | | | | | | | | | |

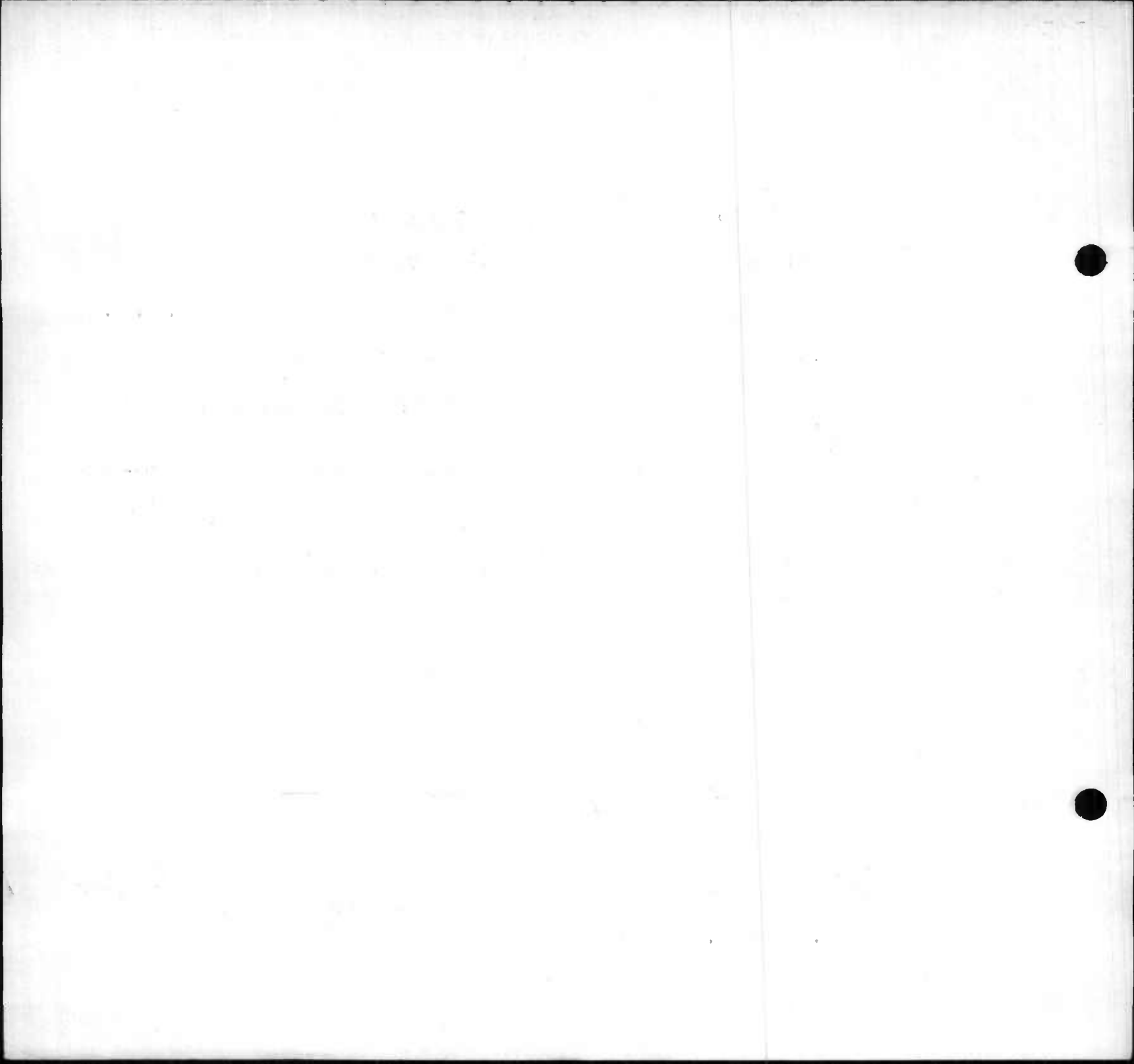


36-54-92
FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04305 | |
|--|-------------------------|--|------------------------------------|---|---|
| BIRTH NO. 66 04305 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) OPPA STATHAM | | | |
| 2. DATE AND HOUR OF DEATH
4/25/66 3:25 A.M. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | A. STATE
MD | | B. COUNTY
Baltimore | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | D. STREET ADDRESS (If rural, give location)
523 MAIN ST 21222 | | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
4/27/10 | 9. AGE (In years last birthday)
55 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
Oscar Patterson | | | |
| 14. MOTHER'S MAIDEN NAME
Sabre Scruggs | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
RECORDS: BCH 4940 Eastern Avenue 21224 | | | |
| 18. 4/21/66 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) Coronary Artery
DUE TO
(B) Coronary Heart Failure
DUE TO
(C) Idiopathic Cardiomyopathy
INTERVAL BETWEEN ONSET AND DEATH
Minutes
12 years
15 years | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/19/66 to 4/25 19 66 , that (I) (we) last saw the deceased alive on 4/25 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Sidney D. Kreider | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/25/66 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Sidney D. Kreider | | 23D. ADDRESS
4940 Eastern Avenue 21224
Balt. City Hospitals | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
APR 27 1966 | | 24C. NAME OF CEMETERY, CREMATORY
Canaan Bapt. Church Appomattox, VA | |
| 24D. LOCATION (City, town, or county) (State)
Appomattox, VA | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR
MORTON J. Dyett F.H. | | ADDRESS
1701 LAURENS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 04306 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04306 | |
|---|--|--|--|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print)
Charles Edward Watts | | | | 2. DATE AND HOUR OF DEATH
4-23-66 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Sinia Hospital (DOA) | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md.
B. COUNTY 15-10 | | | |
| 5. SEX M | | | | 6. RACE Negro | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | |
| 8. DATE OF BIRTH
1-16-1921 | | 9. AGE (In years last birthday)
45 | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Custodian | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Industry | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
Charles E. Watts, Sr. | | | |
| 14. MOTHER'S MAIDEN NAME
Mamie Roberts | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
213-16-6947 | | | |
| 16. SOCIAL SECURITY NO.
213-16-6947 | | | | 17. INFORMANT
Margaret Watts 4002 Boorman Ave. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
420.0 I
CAUSE OF DEATH
A.S.H.D. = H.C. Vascular Component - 2 yrs - | | | | INTERVAL BETWEEN ONSET AND DEATH
2 yrs - | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
N/A | | | | | | | |
| 19A. DATE OF OPERATION
N/A | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
N/A | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
N/A | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)
N/A | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
N/A | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
N/A | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
N/A | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> While On Work <input type="checkbox"/>
N/A | | 21F. HOW DID INJURY OCCUR?
N/A | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 17 Aug 1963 to 8 Apr 1966 that (I) (we) last saw the deceased alive on 8 Apr 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Uthman Ray, Jr., M.D.
2225 W. North Ave. | | | | 23B. DATE SIGNED
26 Apr 66 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Baltimore Md. 21216 | | | | 23D. ADDRESS
Telephone 523-3512 D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-27-66 | | 24C. NAME of CEMETERY or CREMATORY
Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1966 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Morton & Dyett 1701 Laurens St. | | | |

CH = D.H.2A
- Compound

Handwritten notes on lined paper, including the word "Bach" and various mathematical expressions and symbols.

W. J. H. J.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>66 04307</u> | |
|--|-------------------------|--|------------------------------------|---|--|--|------------------------------|
| BIRTH NO. <u>66 04307</u> | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>CAMPBELL, THOMAS D.</u> | | | | 2. DATE AND HOUR OF DEATH
<u>4 . 26 1966</u> <u>10 15</u> P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF INSTITUTION
<u>Lutheran Hospital of Maryland</u> | | (If not in hospital or institution, give street address or location) | | A. STATE
<u>1529 Pulaski St #17</u> | | B. COUNTY | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Same</u> | | D. STREET ADDRESS (If rural, give location)
<u>1529 N. Pulaski ST</u> | |
| 5. SEX
<u>male</u> | 6. RACE
<u>negro</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>6/12/95</u> | 9. AGE (In years last birthday)
<u>70</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Laborer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Be Thlehem Steel</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Forest Depot, VA.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Charles H. Campbell</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Ellen Campbell</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Anna B. Campbell</u> | | ADDRESS
<u>1529 Pulaski ST.</u> | |
| 18. <u>331X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>Cerebro-vascular accident</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Hypertension</u>
<u>Atherosclerosis</u> | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>Bleeding gastric ulcer</u> | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Grumberg</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
<u>GRUMBERG IOSEF</u> | | | | 23D. ADDRESS
<u>Lutheran Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4-29-66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>BALTO NATIONAL Cem.</u> | | 24D. LOCATION (City, town, or county) (State)
<u>BALTO. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 27 1966</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR
<u>Morton + Dyer</u> | | ADDRESS
<u>1701 LAURENS ST.</u> | |

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66 04308

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 04308

BIRTH NO.

M.E. CASE NO.

| | | | | | |
|--|-------------------------|--|---|--|---|
| 1. NAME OF DECEASED
(Type or Print)
RICHARD ANDERSON | | | 2. DATE AND HOUR PRONOUNCED DEAD
April 22, 1966 10:05 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

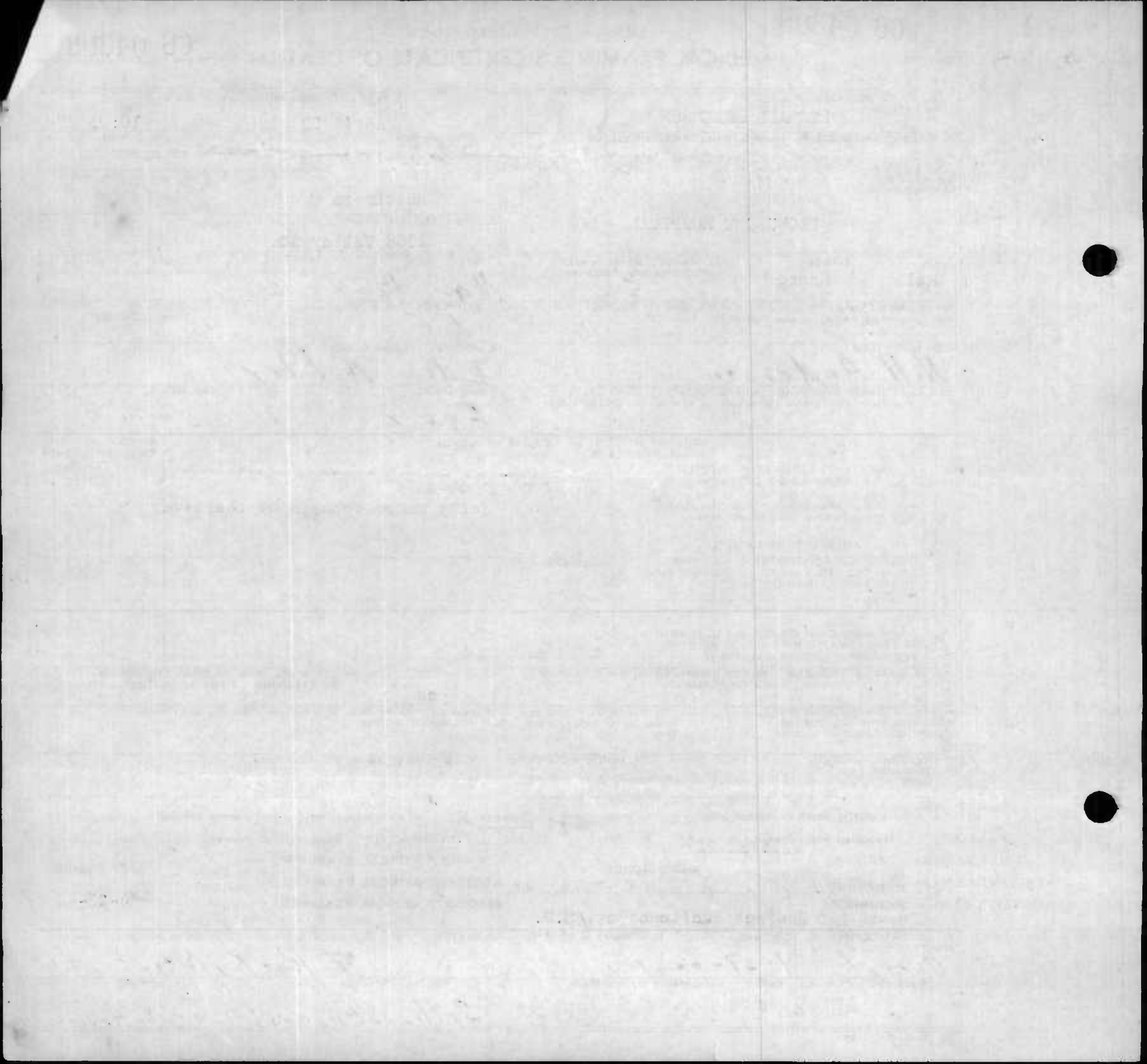
PROVIDENT HOSPITAL - DOA | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1308 Valley St. | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
5 | 8. DATE OF BIRTH
Mar 1924 | 9. AGE (In years last birthday)
42 | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
1960-66 | | 10B. KIND OF BUSINESS OR INDUSTRY
N.C. | | 11. BIRTHPLACE (State or foreign country)
N.C. | |
| 13. FATHER'S NAME
Will Anderson | | | 14. MOTHER'S MAIDEN NAME
Ida Ashley | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Family | |
| | | | | ADDRESS
same | |

| | | | | | |
|---|--|--|--|--|--|
| 18. CAUSE OF DEATH
581.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Bronchopneumonia
fatty metamorphosis of the liver | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>

ACTUAL SIGNATURE Rudiger Breiteneker M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4-23-66
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
4-27-66 | | 23C. NAME OF CEMETERY or CREMATORY
Rural Cem. | |
| 24A. DATE REC'D BY HEALTH DEPT.
APR 28 1966 | | 24B. NAME OF REGISTRAR
Robert E. Farley | | 24C. FUNERAL DIRECTOR
1011-13 Sullivan Funeral Home - N. Arlington | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Rocky Mount N.C. | |



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K 260

66 04309

BALTIMORE CITY HEALTH DEPARTMENT

66 04309

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

| | | | |
|---|---------|--|--|
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| SOLOMON KIEZER KISER | | 4-25-66 10:40 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | |
| JOHNS HOPKINS HOSPITAL - DOA | | Maryland | |
| | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | |
| | | Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) | |
| | | 2020 Ashland Avenue 21205 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH |
| Male | Colored | WIDOW | 1-13-1893 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) |
| | | RETIRED | 73 |
| 13. FATHER'S NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| IRVIN KISE | | U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
| NO | | 237-14-7975 | SARAH JOYNER 1236 N. WASHINGTON ST. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | |
| ANTECEDENT CAUSES | | (B) DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (C) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | Arteriosclerotic cardiovascular disease | |
| | | Neurosyphilis | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) |
| | | | No |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| RUSSELL S. FISHER, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | 23C. NAME OF CEMETERY or CREMATORY |
| Burial | | 4-28-66 | MT-CALVARY |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | 24C. FUNERAL DIRECTOR |
| APR 28 1966 | | Robert E. Farley, M.D. | JOSEPH KNIGHT |
| | | ADDRESS | |
| | | 1639 N. Broadway | |

WATLEY HONGRE

WATLEY HONGRE

WATLEY HONGRE

WATLEY HONGRE

WATLEY HONGRE

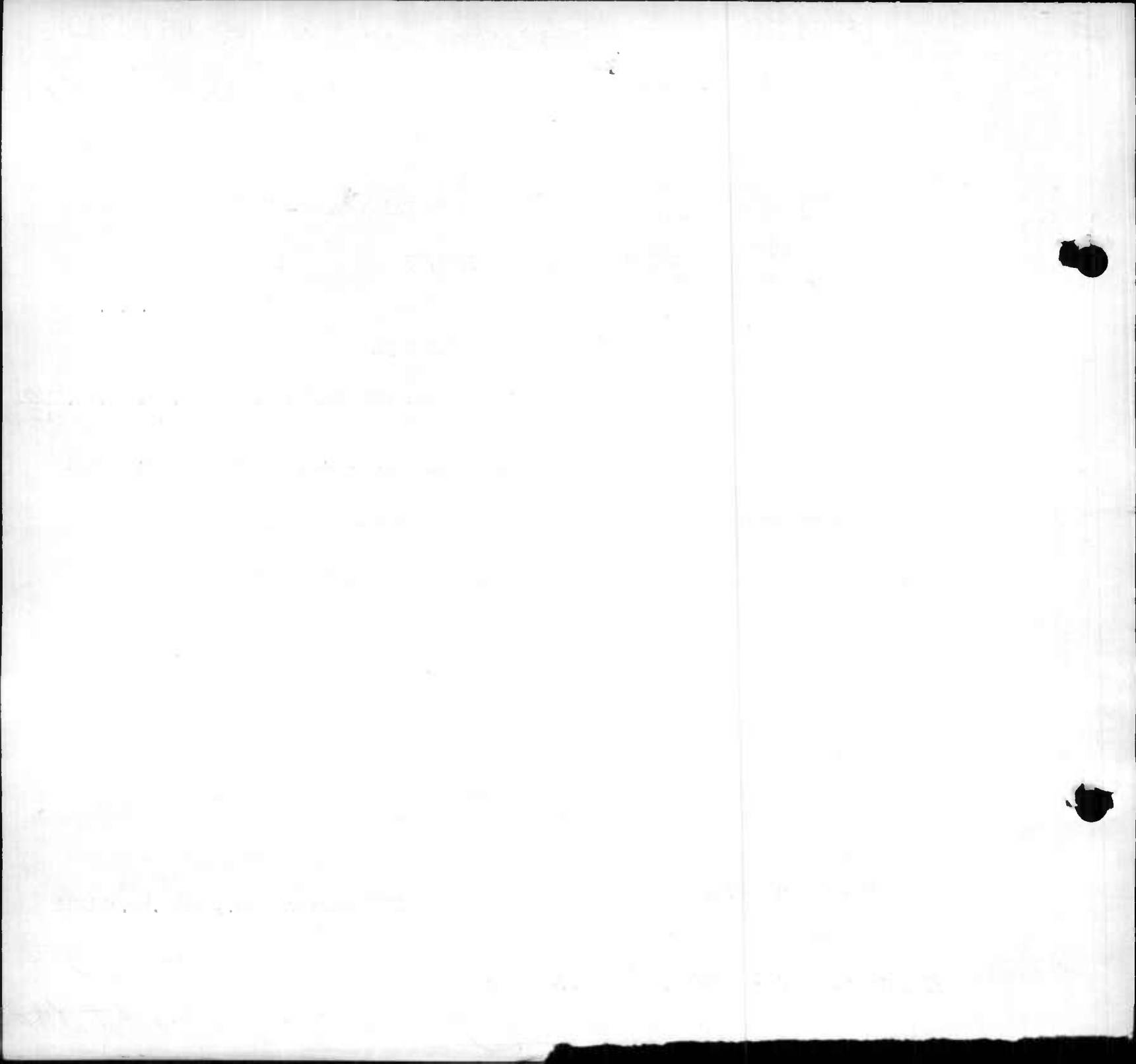
WATLEY HONGRE

WATLEY HONGRE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|-----------------------------|---|---|
| 43-06-55
NW 4601 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04310 | |
| BIRTH NO. 66 04310 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) TAYLOR, Towanda | | 2. DATE AND HOUR OF DEATH
4-22-66 12:20 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY | | 8-07 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE MARYLAND 21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location)
1621 Faith Lane -21205 | | | |
| 5. SEX
FEMALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
NEVER MARRIED | 8. DATE OF BIRTH
3/11/65 | 9. AGE (In years last birthday)
1 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME
CHRISTINE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
RECORDS: BCH 4940 EASTERN AVE., BALTO. MD. 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
754.41
Endocardial Fibroelastosis | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
Congenital | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 4-22-66 to 4-22-66
that (I) (we) last saw the deceased alive on 4-22-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Herbert Kaiser | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/22/66 | |
| 23C. PHYSICIAN'S NAME (Type)
Herbert Kaiser | | 23D. ADDRESS
4940 Eastern Ave., Balto. Md. 21224
Baltimore City Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/27/66 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Calvary | |
| 24D. LOCATION
a. a. County - Md | | 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1966 | | 25B. NAME OF REGISTRAR
R. E. Fisher | |
| 25C. FUNERAL DIRECTOR
Joseph S. Lock | | 25D. ADDRESS
1304 N. Central Ave | | | |



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G. 125

66 04311

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 04311

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FRED GIBSON

2. DATE AND HOUR PRONOUNCED DEAD

4-24-66

7:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

700 E. Baltimore Street 21202

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

11/198

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VA.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WWI

16. SOCIAL
SECURITY NO.

UNKNOWN

17. INFORMANT

ADDRESS

M.T. THURSTON MATHEWS, VA.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Cirrhosis of liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Contusion of left thigh

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRI-
BUTING CAUSE OF DEATH?

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Unknown

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Unknown

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)
4 21 '66

21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Presumably fell

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-25-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

4/27/66

23C. NAME of CEMETERY or CREMATORY

LOMAINE

23D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

24A. DATE REC'D BY HEALTH DEPT.

APR 28 1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Paul E. Chomatos 3617 Chestnut Ave.

ADDRESS

WALLACE FORGE

PAO CONTENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|---|------------------------------------|--|--|
| BIRTH NO. <u>66 04312</u> | | Baltimore City Health Department | | Registered No. <u>66 04312</u> | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>MONTAIGNE JAMES</u> | | 2. DATE AND HOUR OF DEATH
<u>4/26/66</u> <u>7:35 A</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>UNION MEMORIAL HOSP.</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>1306</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u>
D. STREET ADDRESS (If rural, give location)
<u>709 W 36th ST.</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>—</u> | 8. DATE OF BIRTH
<u>9/14/01</u> | 9. AGE (In years last birthday)
<u>64</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>MD</u> | |
| 13. FATHER'S NAME
<u>G. ROUEL MONTAIGNE</u> | | 14. MOTHER'S MAIDEN NAME
<u>ROSALEE DOYLE</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<u>GROVER MONTAIGNE W 36th St.</u> | |
| 18. <u>340.11</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH
(A) <u>Meningitis + Brain Abscess</u>
DUE TO
(B) <u>Pneumococcus</u>
DUE TO
(C) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>10A</u> | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/26</u> 19 <u>66</u> to <u>4/26</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/26</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>[Signature]</u> | | | | 23B. DATE SIGNED
<u>4/26/66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>DR. ERNESTO LEDESMA</u> | | | | 23D. ADDRESS
<u>UNION M. Hosp.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>4/28/66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>BALTO. NATIONAL</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>BALTO. MD.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 28 1966</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Paul E. [Signature]</u> | | | |
| 25D. ADDRESS
<u>7617 [Signature]</u> | | | | | |

THE RESULTS OF THE

B-6531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66 04313

BIRTH NO. 66 04313

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM BRENDEN

2. DATE AND HOUR OF DEATH

April 23, 1966 10:30 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Md. 21206

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4313 Arizona Ave.,

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

3/13/1901

9. AGE (in years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Foreman

10B. KIND OF BUSINESS OR INDUSTRY

Bromo Seltzer

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Louis Brendel

14. MOTHER'S MAIDEN NAME

unknown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

212-01-7922

17. INFORMANT

ADDRESS

Lola Eakers Brendel, wife, above

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the hospital) attended the deceased from 19 66 to March 19 66
that (I) (we) last saw the deceased alive on 30 Mar 19 66 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did not) view the body after death.

23A. SIGNATURE

Thomas J. Brennan

M.D.

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

25 April 66

23C. PHYSICIAN'S
NAME (Type)

Dr. Thomas Brennan

23D. ADDRESS

M.D.

5217 Harford Road

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/27/66

24C. NAME OF CEMETERY or CREMATORY

Moreland Memorial Park

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 28 1966

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.
3331 Brehms Lane

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

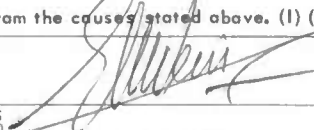
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Approved

10. 10. 10. 10. 10. 10.
10. 10. 10. 10. 10.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------|--|--|--|--|--|---------------------------------|-----------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 66 04314 | | | | |
| BIRTH NO. 66 04314 | | M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED
(Type or Print) JACOBS SR. EDWARD | | T | | | APRIL 22 1966 9:45A M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
ST AGNES HOSPITAL | | | | | A. STATE MD B. COUNTY A. A. Co. | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
LINTHICUM | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
206 REGENCY CIRCLE | | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | | 8. DATE OF BIRTH
6-17-94 | 9. AGE (In years last birthday)
71 | If Under 1 Yr. Months: Days: Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Water Repairman | | 10B. KIND OF BUSINESS OR INDUSTRY
Balto. Water Service | | 11. BIRTHPLACE (State or foreign country)
MD | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | | | |
| 13. FATHER'S NAME
THOMAS JACOBS | | | | 14. MOTHER'S MAIDEN NAME
HELEN --- | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
218-22-1273 | | 17. INFORMANT ADDRESS
ST AGNES HOSPITAL CATON & WILKENS AVE. | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
325-1
Uremia
Cor Pulmonale
Chronic Lung Fibrosis | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-26-66 19 to 4-22 19 66, that (I) (we) last saw the deceased alive on APRIL 22 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
 | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
4-22-66 | |
| 23C. PHYSICIAN'S NAME (Type)
EWALDO WEISS | | | | | 23D. ADDRESS
M.D. CATON & WILKENS AVE. BALTIMORE MD | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Apr. 26, 66 | | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1966 | | 25B. NAME OF REGISTRAR
R. E. Farley | | 25C. FUNERAL DIRECTOR
George J. Gonce - 4001 Ritchie Hwy. | | | ADDRESS
Baltimore, Md. 21225 | | |

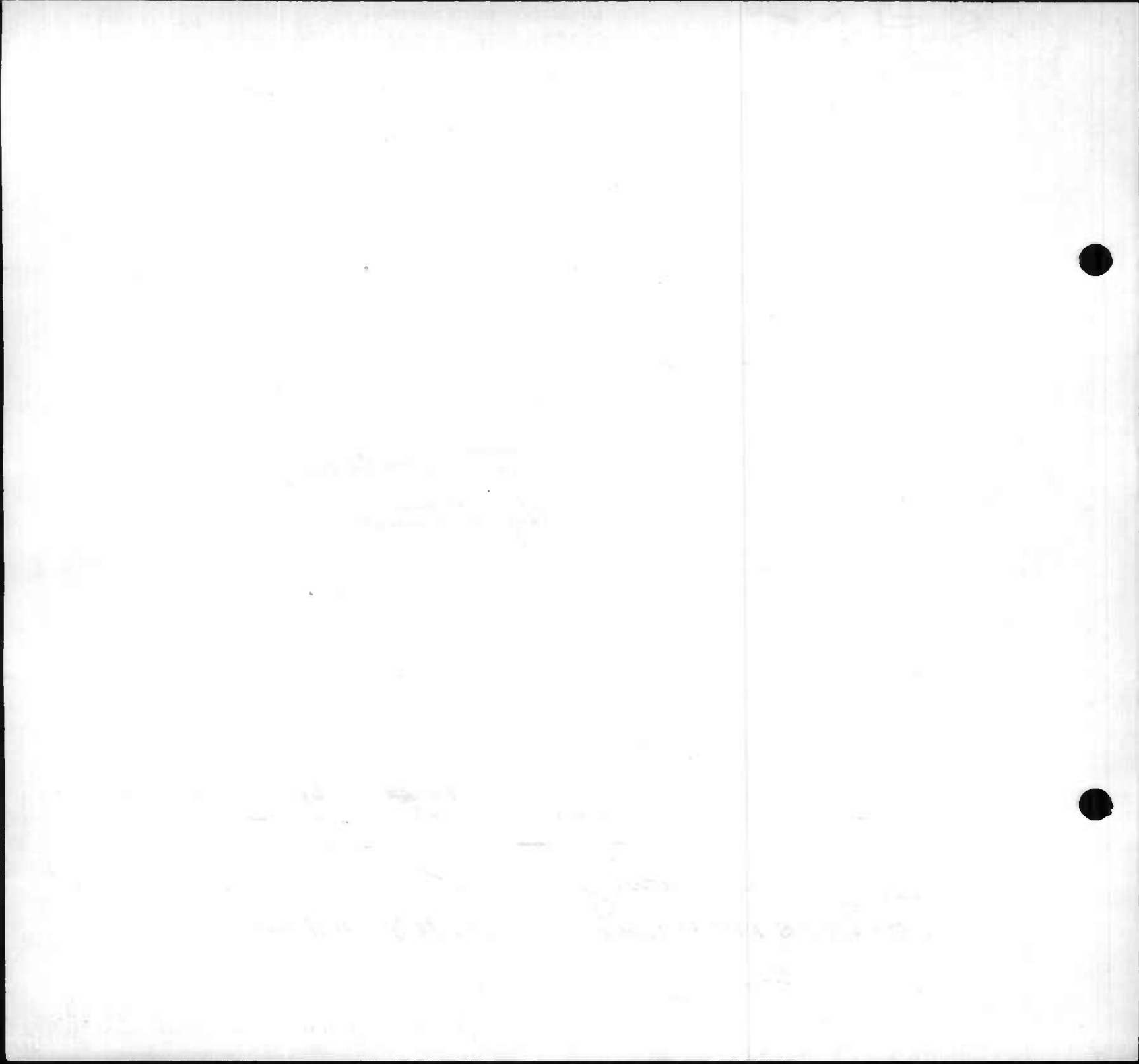
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|--|--|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>66 04315</u> | | | | |
| BIRTH NO. <u>66 04315</u> | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>THEODORE J. PHILLIPS</u> | | | | | 2. DATE AND HOUR OF DEATH
<u>4-25-66</u> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>916 S. BAYLIS</u> | | | | | A. STATE
<u>MARYLAND</u> | | | | |
| | | | | | B. COUNTY
<u>26-09</u> | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
<u>916 S. BAYLIS ST.</u> | | | | |
| 5. SEX
<u>MALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | | 8. DATE OF BIRTH
<u>1-9-1888</u> | 9. AGE (In years last birthday)
<u>78</u> | If Under 1 Yr.
Months Days | | If Under 24 Hrs.
Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>STATIONERY ENG.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>SCHOOL SYSTEM</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A</u> | | | |
| 13. FATHER'S NAME
<u>GEORGE PHILLIPS</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>IDA ZEMM</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>220-05-9147</u> | | 17. INFORMANT
<u>MRS. CAROLINE PHILLIPS</u> | | | ADDRESS
<u>916 S. BAYLIS</u> | | |
| 18. <u>443X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

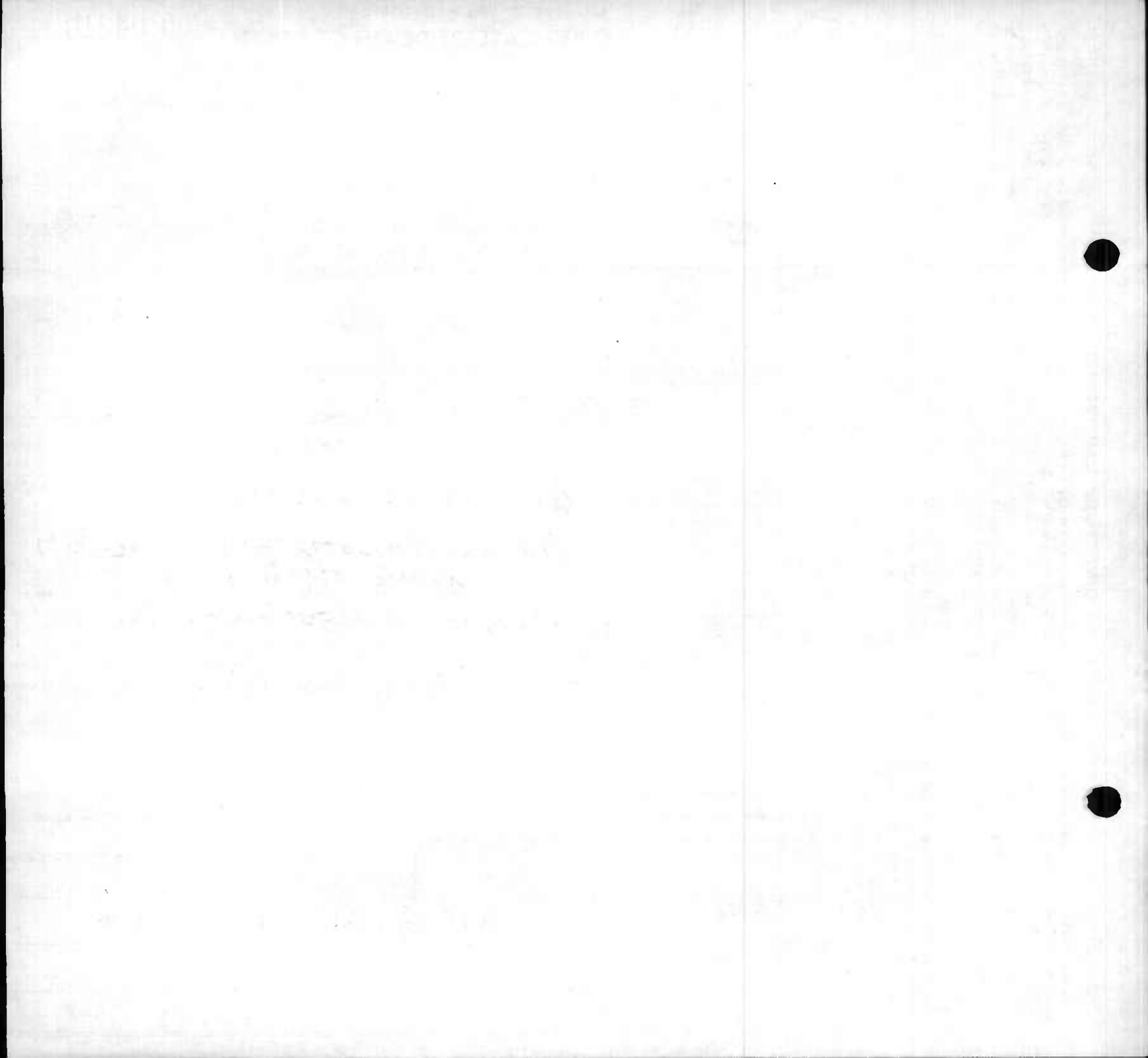
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH
(A) <u>arteriosclerotic Cardiovascular disease</u>
DUE TO
(B) <u>Hypertension</u>
DUE TO
(C) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 da.</u>
<u>5 y 10 -</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-25-1961</u> to <u>4-25-1966</u> , that (I) was last saw the deceased alive on <u>4-25-1966</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<u>Stanley B. Klyanowicz</u> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>4/27/66</u> | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>STANLEY B. KLITANOWICZ</u> | | | | | 23D. ADDRESS
<u>1016 S. EAST AVE, Balto Md -</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>4-28-1966</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>SCHWARTZ'S CEMETERY</u> | | 24D. LOCATION (City, town, or county) (State)
<u>BALTIMORE, MD.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 28 1966</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Fisher, M.D.</u> | | | 25C. FUNERAL DIRECTOR
<u>HOFFMANN FUNERAL HOME</u> | | | ADDRESS
<u>3218 HUDSON ST.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

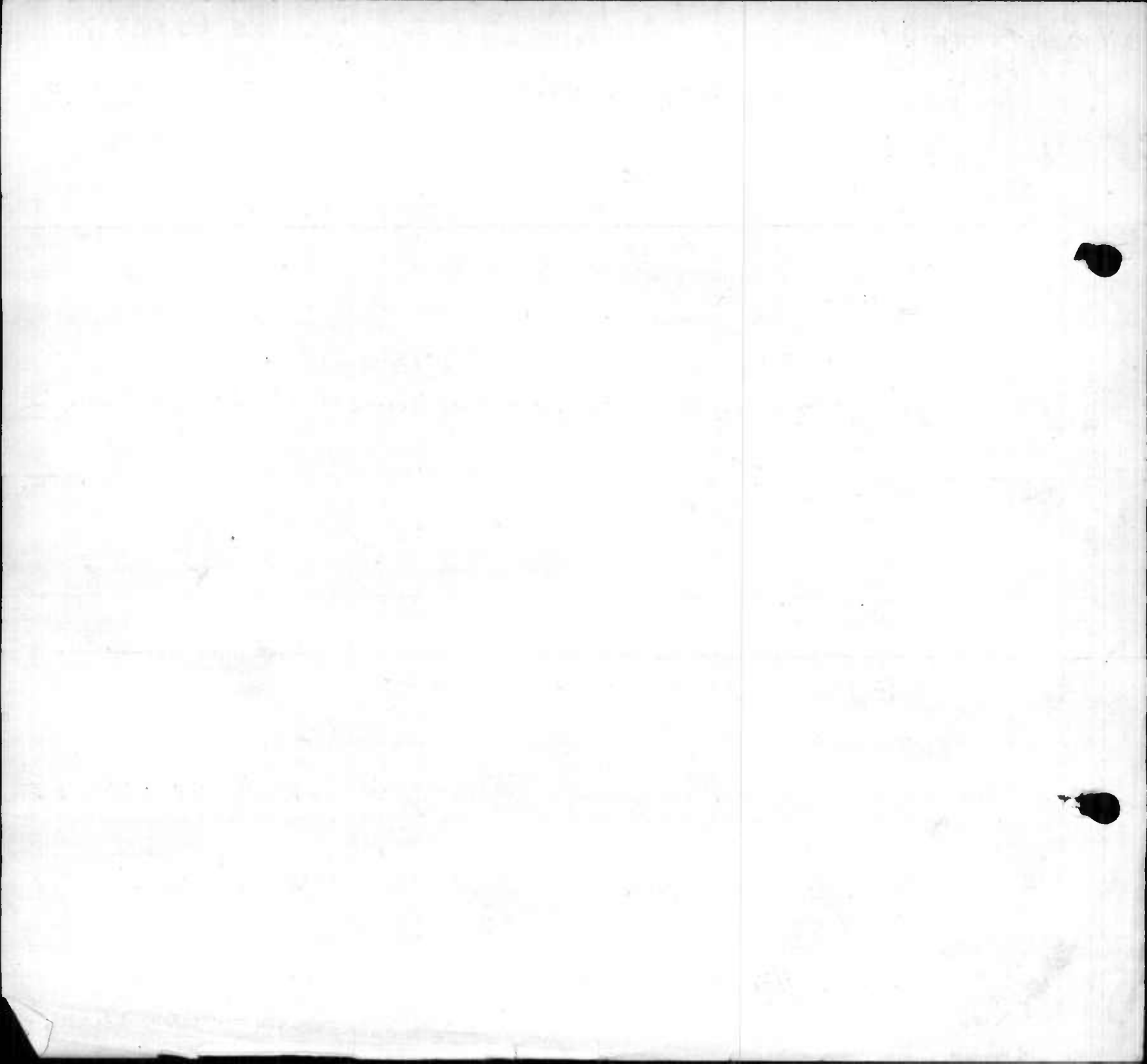
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-----------------------|---|---|--|--|---|--|------------------------------------|--|
| C. 6121 | | | | | 66 04316 | | | | |
| BIRTH NO. | | | | | 66 04316 | | | | |
| M.E. CASE NO. | | | | | 66 04316 | | | | |
| 1. NAME OF DECEASED
(Type or Print) LAWRENCE F. CARBACK | | | | | 2. DATE AND HOUR OF DEATH
April 23 1966 7⁰⁵ P. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY 12-05 | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
MARYLAND GENERAL Hospital | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTO 18 | | | | |
| D. STREET ADDRESS (If rural, give location)
2006 St Paul St Apt 2B | | | | | | | | | |
| 5. SEX
M | 6. RACE
Can | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
6/28/94 | 9. AGE (In years last birthday)
72 | 11. BIRTHPLACE (State or foreign country)
BALTO | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | | 10B. KIND OF BUSINESS OR INDUSTRY
--- | | | | | | |
| 13. FATHER'S NAME
George M. Carback | | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
211-01-5500 | | 17. INFORMANT
Francis Beck ADDRESS HARRISHT AVE MI 4 4867
Landstown Md. | | | | |
| 18. 154 X 1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Pulmonary edema
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Anemic Heart Disease
Adenocarcinoma (2) of Rectum, chronic bleeding | | | | | CAUSE OF DEATH
INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Hypertensive Cardiovascular Dis. | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/22 19 66 to 4/23 19 66 , that (I) (we) last saw the deceased alive on 4/23 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Donald E. Lewis | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
4/23/66 | |
| 23C. PHYSICIAN'S NAME (Type)
MD G. M. Hays, BALTO. | | | | | 23D. ADDRESS | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
CREMATION | | 24B. DATE
4/27/66 | | 24C. NAME of CEMETERY or CREMATORY
LOWOON PARK | | | 24D. LOCATION (City, town, or county) (State)
BALTO, MD, | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1966 | | | 25B. NAME OF REGISTRAR
Robert E. Farley, M.D. | | | 25C. FUNERAL DIRECTOR
Paul E. Charon ADDRESS 3617 Chas. Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|---------------------|---|--|--|--|--|---|---|---------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>66 04317</u> | | | | | |
| BIRTH NO. <u>66 04317</u> | | | | | M.E. CASE NO. <u>66 04317</u> | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Robert Wesley Windsor</u> | | | | | 2. DATE AND HOUR OF DEATH
<u>April 25th 1966 2:30 p.m.</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
<u>University Hospital</u> | | | | | A. STATE
<u>Md.</u> | | | | | |
| | | | | | B. COUNTY
<u>Marion Station</u> | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Somerset</u> | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
<u>69-00</u> | | | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Married</u> | | 8. DATE OF BIRTH
<u>12/8 '23</u> | 9. AGE (In years last birthday)
<u>42</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>(Unemployed)</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Body & Fender Shop</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Md</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 13. FATHER'S NAME
<u>Robert W.</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Tressie Elliott</u> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>Yes</u> <u>WORLD WAR II</u> | | | | 16. SOCIAL SECURITY NO.
<u>218-20-6975</u> | | 17. INFORMANT
<u>MRS. ELEANOR WINDSOR - MARION STATION, MD.</u> | | | | |
| 18. <u>545X1</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Cardiac Arrest</u> | | | | (A) DUE TO <u>Peritonitis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO <u>Leading Duodenal Ulcer</u> | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>4/25/66</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>GI bleeding</u> | | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>April 12th 1966</u> to <u>April 25th 1966</u> , that (I) (we) last saw the deceased alive on <u>April 25th 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE
<u>Wgl. Joe Parkinson</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
<u>April 25th 66</u> | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Vig. Thor Thorsteinsson</u> | | | | | 23D. ADDRESS
<u>University Hospital</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>4/29/66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>ST. PAUL'S CEMETERY</u> | | | 24D. LOCATION (City, town, or county) (State)
<u>MARION STATION, MD.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 28 1966</u> | | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | | 25C. FUNERAL DIRECTOR
<u>BRADSHAW & SONS - CRISFIELD, MD.</u> | | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|---|--|--|---|
| BIRTH NO. 66 04318 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04318 | |
| 1. NAME OF DECEASED
(Type or Print) Wiley Sims | | | | 2. DATE AND HOUR OF DEATH
April 25, 1966 12:20a M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital
1514 Division Street
Baltimore, Maryland 21217 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 14-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1343 W. North Avenue | |
| 5. SEX
Male | 6. RACE
C | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
widowed | 8. DATE OF BIRTH
July 6, 1894 | 9. AGE (In years last birthday)
71 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10B. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Georgia | |
| 13. FATHER'S NAME
Unknown | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 14. MOTHER'S MAIDEN NAME
Unknown | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes | | |
| 16. SOCIAL SECURITY NO.
228-05-6159 | | | 17. INFORMANT ADDRESS
James Curtis-friend 1548 W. North Avenue | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) ASHD
DUE TO
(B) Myocardial Anoxia
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 21, 1966 to April 25, 1966 , that (I) (we) last saw the deceased alive on April 25, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>R. Theodore</i> | | | | 23B. DATE SIGNED
April 25, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
Roger Theodore | | | | 23D. ADDRESS
M.D. 1514 Division Street-Baltimore 17, Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-29-66 | | 24C. NAME OF CEMETERY OR CREMATORY
Baltimore Nat'l Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1966 | | | |
| 25B. NAME OF REGISTRAR
<i>Robert E. Folsom, M.D.</i> | | 25C. FUNERAL DIRECTOR ADDRESS
<i>George Kelson 1348 Calhoun St.</i> | | | |

1955-56, 1956-57, 1957-58

July 2, 1955

Georgia

Unknown

1955-56, 1956-57, 1957-58

1955-56, 1956-57, 1957-58

Unknown

None

Unknown

None

1955-56, 1956-57, 1957-58

1955-56, 1956-57, 1957-58

April 2, 1955

April 2, 1955

Robert Thacker

1955-56, 1956-57, 1957-58

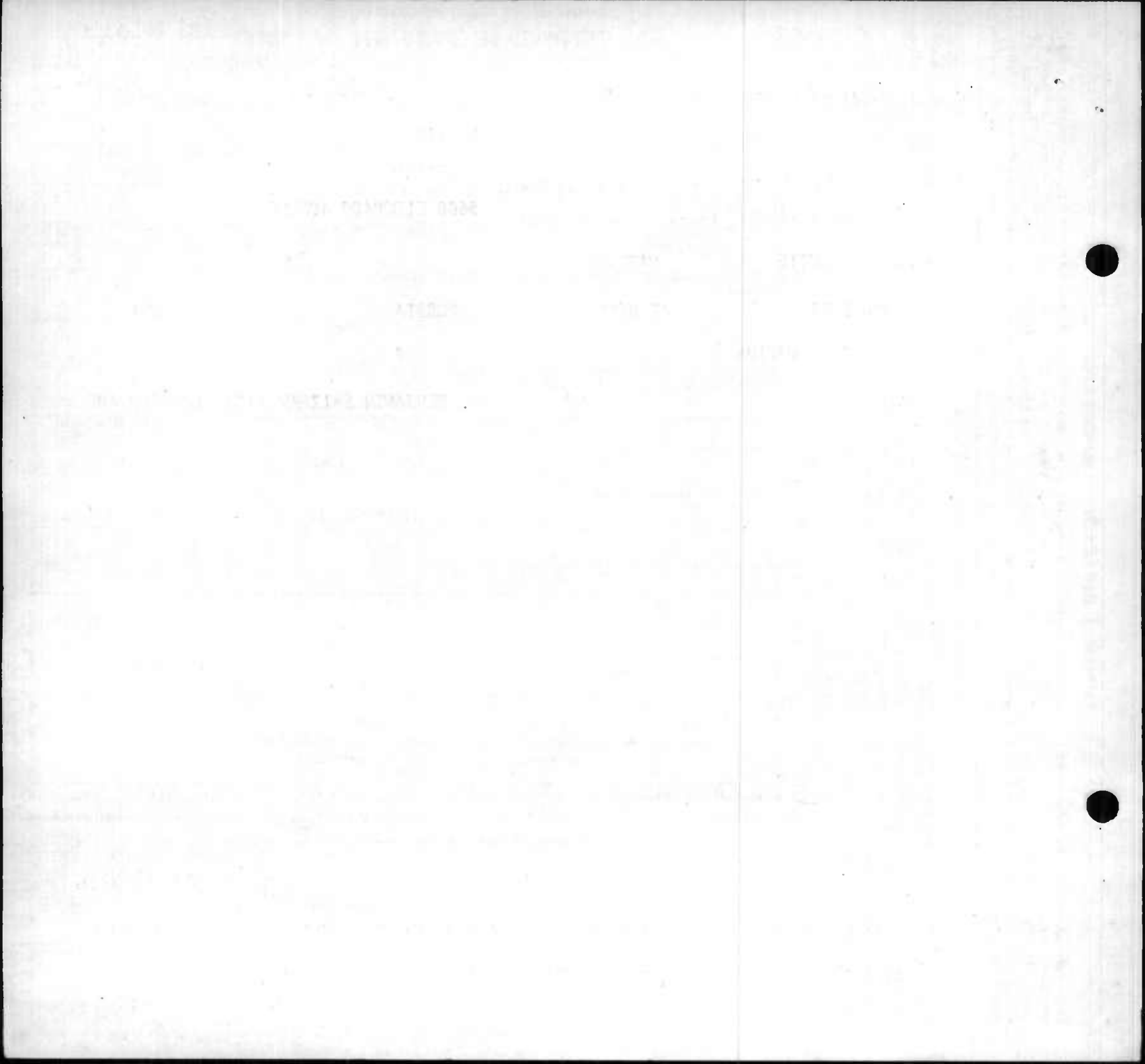
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

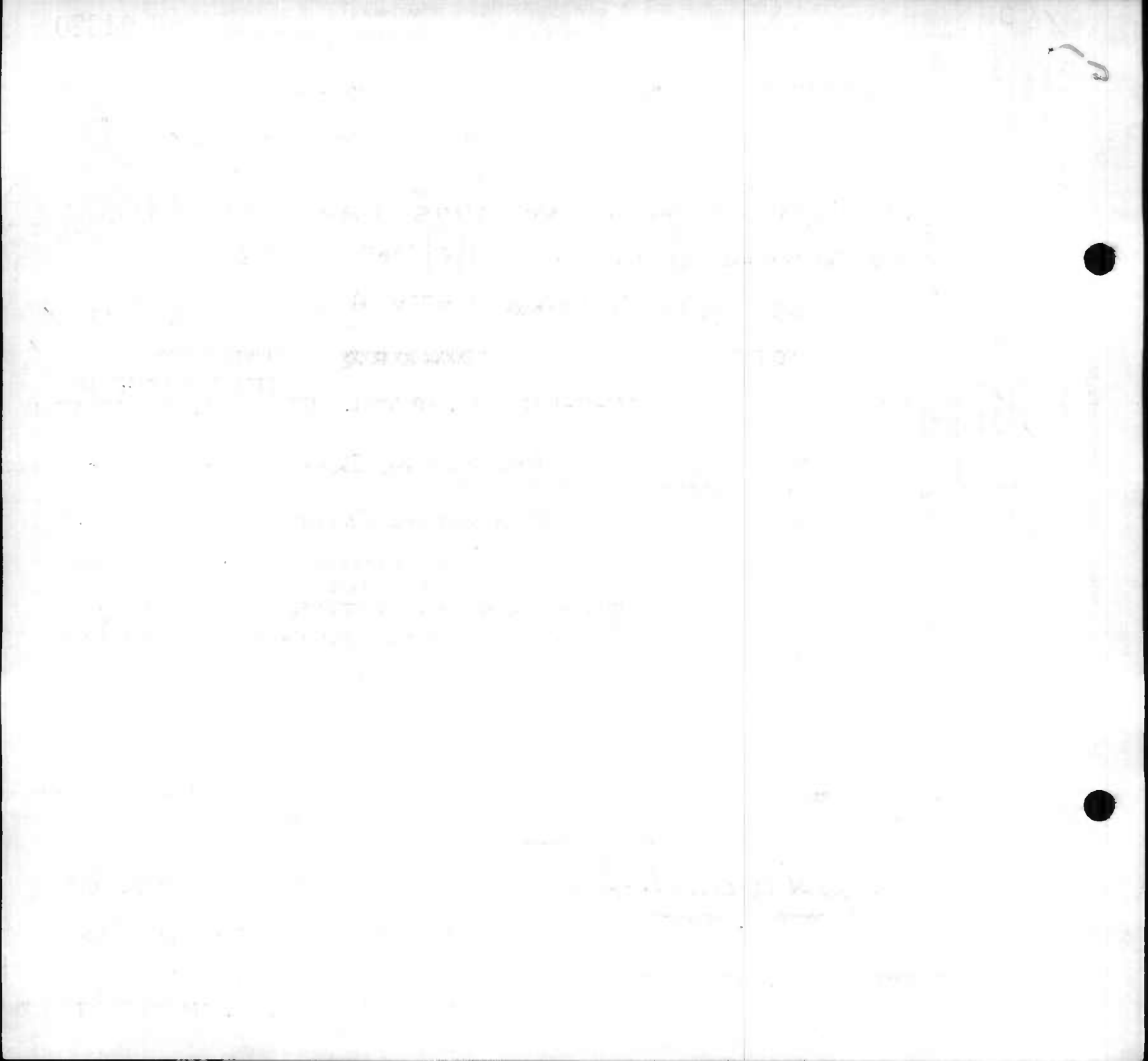
Registered No. 66 04319

| | | | |
|--|--|--|--|
| BIRTH NO. 66 04319 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print) <u>SALZMAN, Bessie</u> | | 2. DATE AND HOUR OF DEATH
<u>4-25-66</u> <u>10:15 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Jewish Convalescent + Nursing Home</u>
<u>4601 PAIL MAIL ROAD, Balto. Md.</u> | | A. STATE <u>MARYLAND</u>
B. COUNTY <u>28-41</u> | |
| 5. SEX <u>Female</u> | | 6. RACE <u>WHITE</u> | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | | 8. DATE OF BIRTH <u>78</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 11. BIRTHPLACE (State or foreign country)
<u>RUSSIA</u> | |
| 10B. KIND OF BUSINESS OR INDUSTRY
<u>AT HOME</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>? WAGMAN</u> | | 14. MOTHER'S MAIDEN NAME
<u>?</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>NO</u> | |
| 17. INFORMANT
<u>MR. BENJAMIN SALZMAN 3600 ELDORADO AVE</u> | | ADDRESS | |
| 18. <u>204.01</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
<u>URINARY TRACT INFECTION</u>
DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
<u>5 MONTHS</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>CHRONIC LYMPHATIC LEUKEMIA</u>
DUE TO | | <u>9 MONTHS</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
<u>None</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<u>NO</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>OCT. 19 65</u> to <u>25 APR 66</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>13 APR 66</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<u>Malcolm S. Druskin</u> | | 23B. DATE SIGNED
<u>25 APR 66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>MALCOLM S. DRUSKIN</u> | | 23D. ADDRESS
<u>2217 SOUTH ROAD, BALTO 9, MD.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>4/26/66</u> | |
| 24C. NAME OF CEMETERY or CREMATORY
<u>BETH HAMEDROSH HAGODOL</u> | | 24D. LOCATION (City, town, or county) (State)
<u>ROSEDALE, MARYLAND</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 28 1966</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | |
| 25C. FUNERAL DIRECTOR
<u>Salomonson + Bros</u> | | ADDRESS
<u>6010 Reisterstown Rd</u> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 04320 | |
|--|-----------------------------|---|--------------------------------------|--|----------------------------|---|-----------------------------|
| BIRTH NO. 66 04320 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) ESTHER KLEIN | | 2. DATE AND HOUR OF DEATH
4/26/66 12¹² P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE N.Y. B. COUNTY BRONX | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
SINAI HOSP. OF BALTO, INC. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
N.Y.C. 10453 | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
1775 DAVIDSON AVE. | | | |
| 5. SEX
FEMALE | 6. RACE
CAUCASIAN | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
11/8/1907 | 9. AGE (In years last birthday)
58 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SEAMSTRESS | | 10B. KIND OF BUSINESS OR INDUSTRY
DRESSMAKING | | 11. BIRTHPLACE (State or foreign country)
LATVIA RUSSIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
HARRY SCHERR | | | | 14. MOTHER'S MAIDEN NAME
FANNIE FELTON | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-05-1627 | | 17. INFORMANT ADDRESS
2156 CRUIGER AVENUE
MR. HOWARD L. KLEIN BRONX, NEW YORK APT 1M | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
#20.17260X
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH
(A) MYOCARDIAL INFARCTION X2 20 & 7 DAYS
DUE TO | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | (B) MYOCARDIAL INSUFFICIENCY > 2 YRS
DUE TO | | | |
| | | | | (C) HYPERTENSIVE ARTERIO-SCLEROTIC > 7 YRS.
CARDIO-VASCULAR DISEASE | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | DIABETES MELLITUS
GASTRO-INTESTINAL HEMORRHAGE | | | |
| 19A. DATE OF OPERATION
None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
None | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
None | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
1 Month () 1 Day () 1 Year () 1 Hour () | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (this hospital) attended the deceased from 4/6 19 66 to 4/26 19 66 , that (we) last saw the deceased alive on 4/26 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Joseph S. Weinstock | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/26/66 | |
| 23C. PHYSICIAN'S NAME (Type)
JOSEPH S. WEINSTOCK | | | | 23D. ADDRESS
M.D. SINAI HOSP. of BALTO, INC | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
REMOVAL | | 24B. DATE
4/28/66 | | 24C. NAME OF CEMETERY or CREMATORY
BETH ISRAEL | | 24D. LOCATION (City, town, or county) (State)
WOODBIDGE, NEW JERSEY | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1966 | | 25B. NAME OF REGISTRAR
Robert E. Fairbank | | 25C. FUNERAL DIRECTOR ADDRESS
SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>66 04321</u> | |
|---|-------------------------|---|-------------------------------------|--|---|---|---------------------------------|
| BIRTH NO. <u>66 04321</u> | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>BENJAMIN BRANDORFF</u> | | | | 2. DATE AND HOUR OF DEATH
<u>4-27-66</u> <u>9:31 A.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MD.</u> B. COUNTY <u>28-31</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>UNION MEMORIAL HOSPITAL</u> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>5316 LYNVIEW AVENUE</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>1-1-1900</u> | 9. AGE
years <u>66</u>
last b'p <u>66</u> | If Under 1 Yr.
Months: Days: Hours: Min. | | If Under 24 Hrs.
Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>MERCHANT</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>RESTAURANT</u> | | 11. BIRTHPLACE (State or foreign country)
<u>RUSSIA</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>PHILLIP BRANDORFF</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>SARAH E. RABINOWITZ</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>214-18-2209</u> | | 17. INFORMANT
<u>WIFE Mrs. Goldie Brandorff</u> | | ADDRESS
<u>SAME</u> | |
| 18. <u>420.11</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
<u>MYOCARDIAL INFARCTION EVOLVING</u>
DUE TO <u>4-13-66</u>
<u>4-27-66</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4-13-66</u>
<u>4-27-66</u> | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) <u>EXTENSION OF INFARCT.</u>
DUE TO <u>4-27-66</u> | | | |
| | | | | (C) _____ | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>INSULT OF OPERATION ETC</u> | | | | | | | |
| 19A. DATE OF OPERATION
<u>4-19-66</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>RT. LUMBAR SYMPATHECTOMY</u> | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <u>he</u> (this hospital) attended the deceased from <u>4-12-1966</u> to <u>4-27-1966</u> , that (I) <u>was</u> lost saw the deceased alive on <u>4-27-1966</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>was</u> (did) <u>not</u> view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Arthur M. LaBruce Jr</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>4-27-66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>ARTHUR M. LA BRUCE, JR.</u> | | | | 23D. ADDRESS
<u>UNION MEMORIAL HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>4/28/66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Chinich Cemetery (Baltimore)</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 28 1966</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR
<u>St. Levinson & Bros Inc</u> | | ADDRESS
<u>6010 Ruston Rd</u> | |

8

1-1-1

1011-2

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1011-2

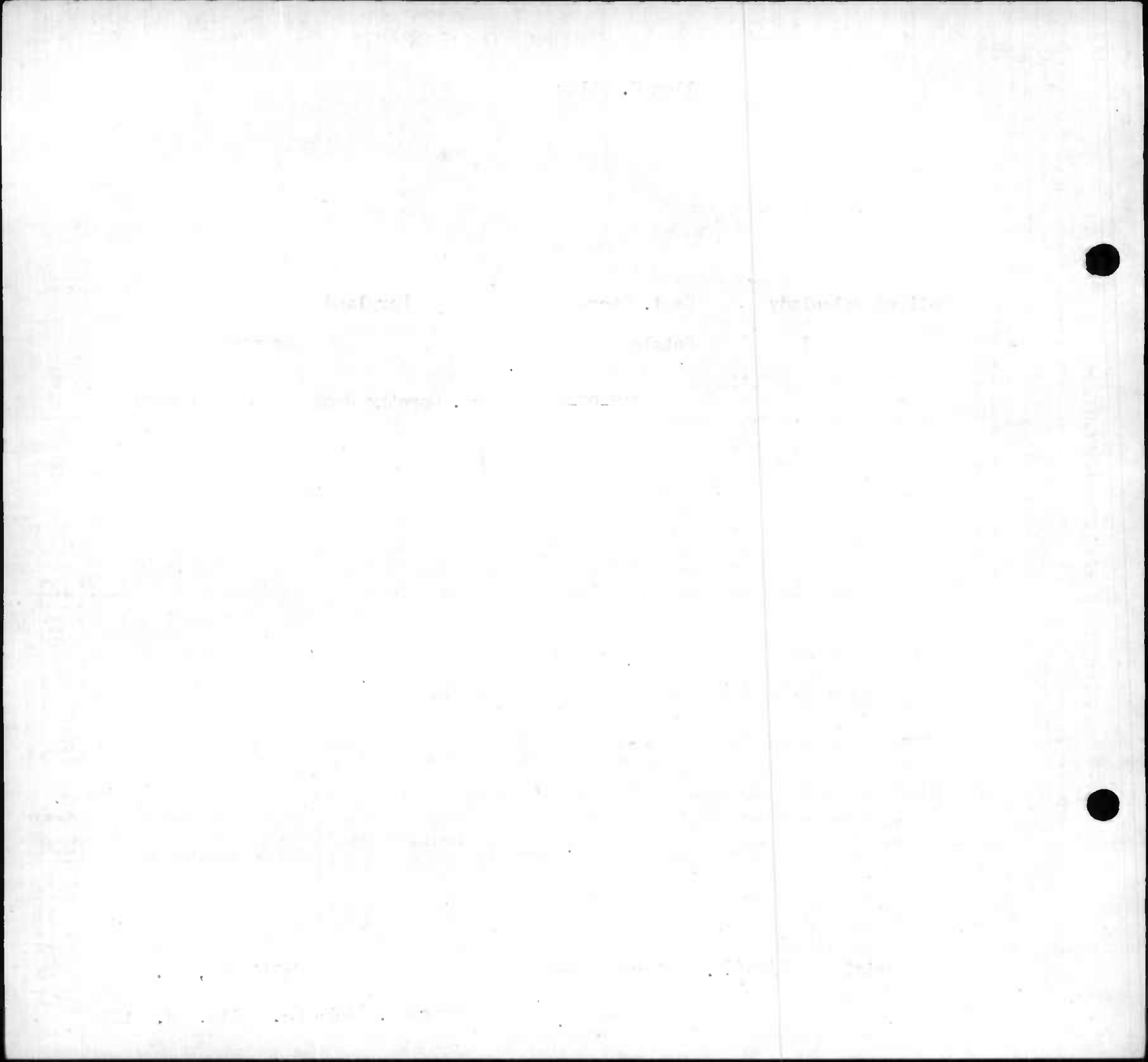
1011-2

1011-2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|------------------------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | 66 04322 | | 66 04322 | |
| BIRTH NO. 66 04322 | | CERTIFICATE OF DEATH | | Registered No. | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) (UHLER, ELLEN) Ellen C. Uhler | | 2. DATE AND HOUR OF DEATH
4-26-66, 5-53 AM. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND. B. COUNTY Balto | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
LUTHERAN HOSPITAL OF MARYLAND,
730-ASHBURTON STREET.
BALTIMORE - MD. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE. #34 | | | |
| | | D. STREET ADDRESS (If rural, give location)
2512 Taylor Ave. | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
W | 8. DATE OF BIRTH
11-3-83 | 9. AGE (In years last birthday)
82 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Saleslady | | 10B. KIND OF BUSINESS OR INDUSTRY
Dept. Store | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
? Boteler | | | |
| 14. MOTHER'S MAIDEN NAME
Unknown | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
217-03-8252 | | 17. INFORMANT ADDRESS
Mrs. Dorothy Back (Same) | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
444XI
Uremia | | INTERVAL BETWEEN ONSET AND DEATH
Few months. | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO
Hypertension | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (B) DUE TO | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-21-1966 to 4-26-1966 , that (I) (we) last saw the deceased alive on 4-25-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Lawrence A. Mehwood | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4-26-66 | |
| 23C. PHYSICIAN'S NAME (Type)
LAWRENCE MEHWOOD | | 23D. ADDRESS
Lutheran Hospital of Maryland, Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL
Burial | | 24B. DATE
4/29/66. | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Cemetery | |
| 24D. LOCATION
Baltimore, Md. | | 24E. (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1966 | | 25B. NAME OF REGISTRAR
R. E. E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
Leonard J. Ruck Inc. Balto. Md. 21214 | |

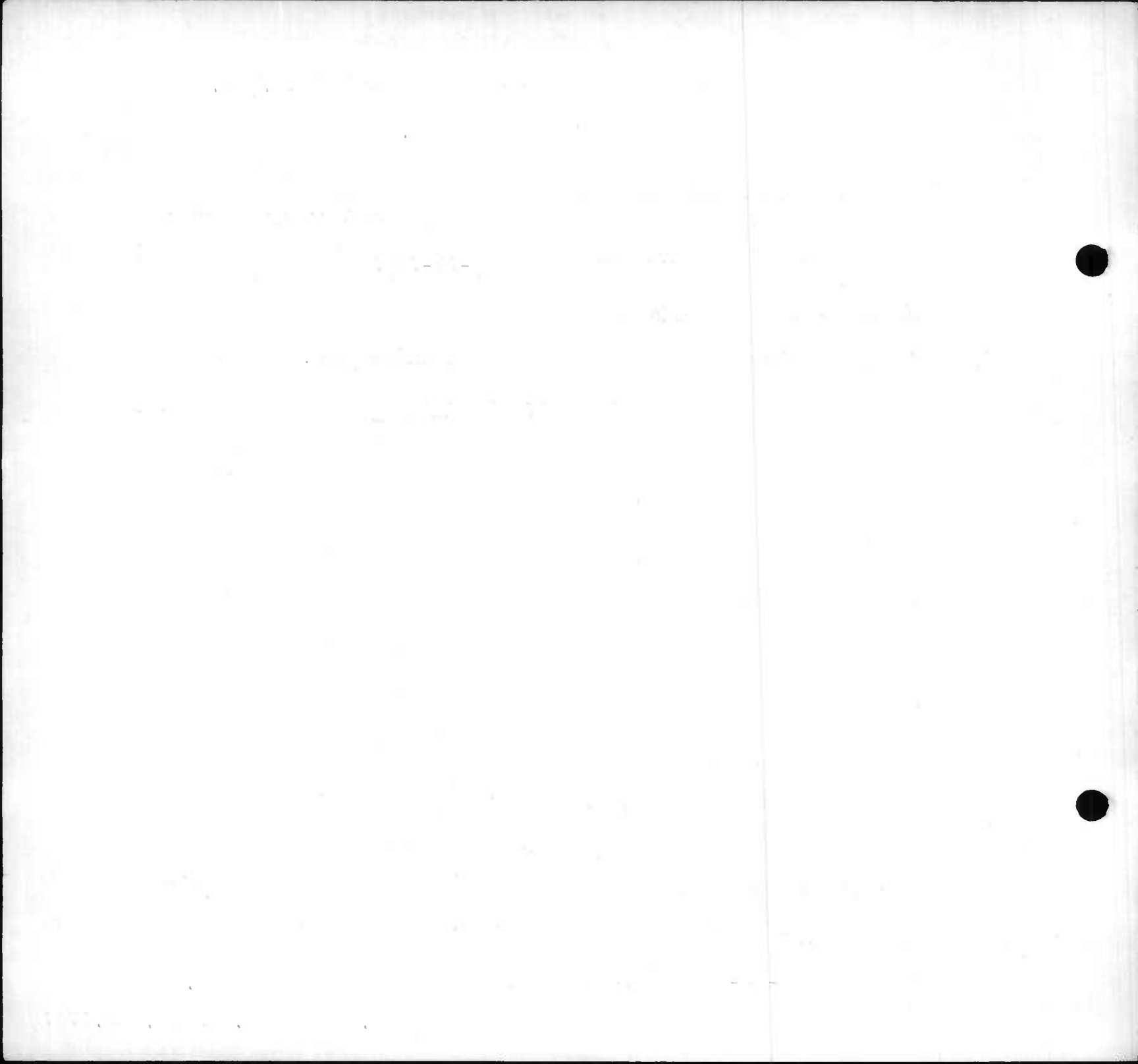


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

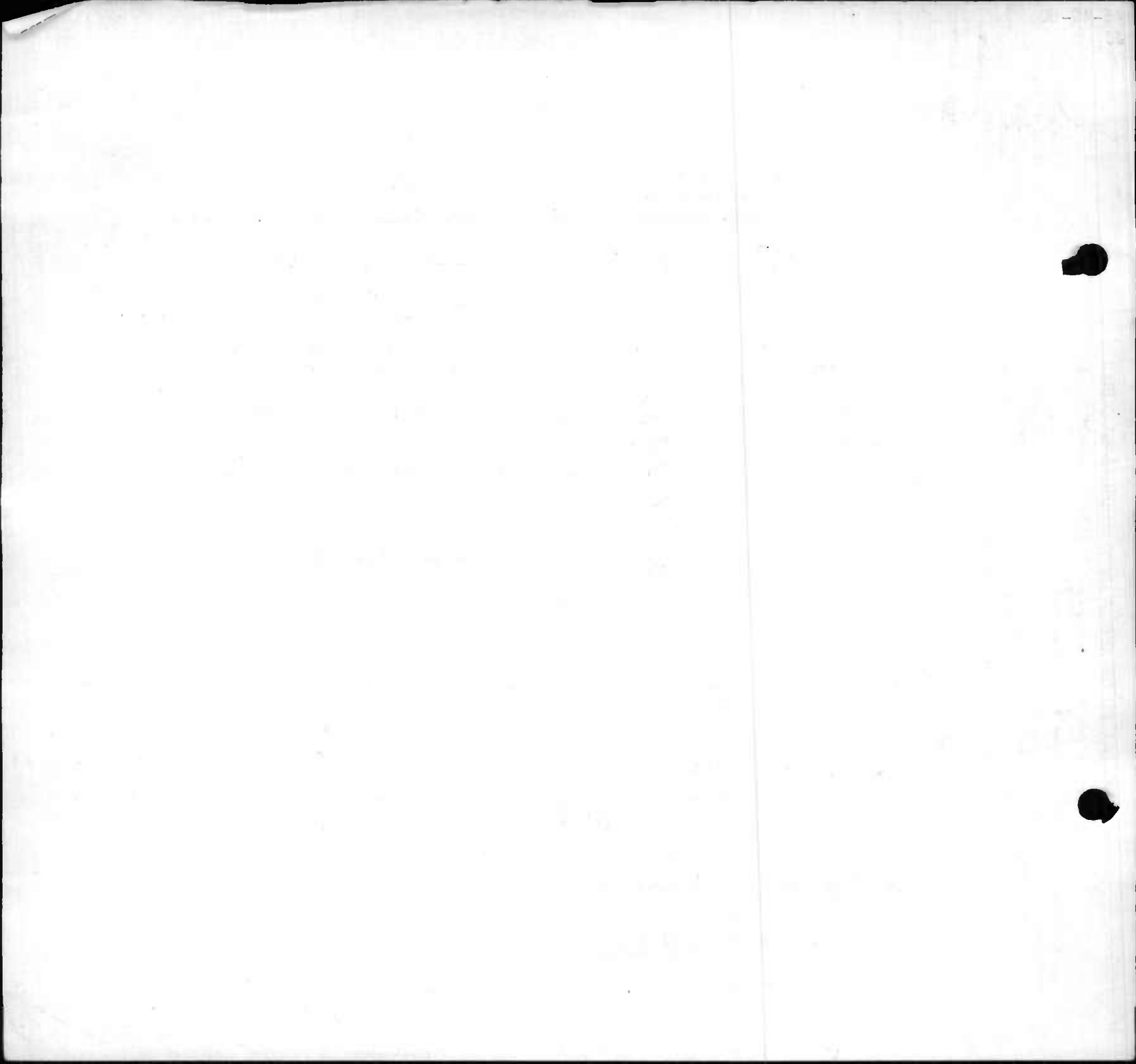
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>66 04323</u> | |
|--|-------------------------|---|--------------------------------------|--|----------------------------|--|-----------------------------|
| BIRTH NO. <u>66 04323</u> | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Mariano</u> | | <u>Ciurca</u> | | 2. DATE AND HOUR OF DEATH
<u>April 26, 1966.</u> | | <u>6:50 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Baltimore City Hospital</u> | | | | A. STATE <u>Md.</u> B. COUNTY <u>8-01</u> | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>3607 Harford Road</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
<u>Married</u> | 8. DATE OF BIRTH
<u>4-17-1891</u> | 9. AGE (In years last birthday)
<u>75</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Tailor</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>clothing</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Italy</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Joseph Ciurca</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Angelina Gangi</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>217329821</u> | | 17. INFORMANT
<u>Luigina Ciurca</u> | | ADDRESS
<u>same</u> | |
| 18. <u>4-22-11</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) <u>ARTERIOSCLEROTIC C.V. DIS</u>
DUE TO
(B) _____
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>5-10 YRS</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/1</u> 19 <u>66</u> to <u>4/26</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/20</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Benjamin Highstein</u> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>4/27/66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>DR. B. HIGHSTEIN</u> | | | | 23D. ADDRESS
M.D. <u>121 S. HIGHLAND AVE BALTO. 24, MD</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>entombment</u> | | 24B. DATE
<u>4-30-66</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Holy Redeemer Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 28 1966</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Fisher, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Leonard J. Ruck Inc. Balto. Md.</u> | | ADDRESS
<u>21214</u> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|---|------------------------------|---|---|
| BIRTH NO. 66 04324 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04324 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) John Gordon | | 2. DATE AND HOUR OF DEATH
April 24, 1966 6:25 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MARYLAND
B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
126 SOLLERS POINT RD. #21222 | | | |
| 5. SEX
MALE | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
4-5-1892 | 9. AGE (In years last birthday)
74 | 10. Under 1 Yr. Months Days
11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
UNKNOWN | | 14. MOTHER'S MAIDEN NAME
UNKNOWN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
RECORDS: BCH 4940 EASTERN AVENUE #21224 | |
| 18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
Pneumonia
Coma
Subdural & Intracerebral Hematoma | | INTERVAL BETWEEN ONSET AND DEATH
2 days
5 days
14 days | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
April 13, 1966 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Subdural & Intracerebral Hematoma | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
126 Sollers Pt Rd | |
| 21D. TIME OF INJURY (APPROX.)
April 11, 1966 | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Pt fell down stairs while drinking | |
| 22. I certify that (I) (this hospital) attended the deceased from April 10, 1966 to April 24, 1966, that (I) (we) last saw the deceased alive on April 24, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Stephen Gregg | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/24/66 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. STEPHEN GREGG | | 23D. ADDRESS
M.D. 4940 EASTERN AVENUE #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-30-66 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cemetery | |
| 24D. LOCATION
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1966 | | | |
| 25B. NAME OF REGISTRAR
R. E. Taylor | | 25C. FUNERAL DIRECTOR
Long H. Kilam 1348 Calhoun St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 66 04325 | |
|---|---------------------|---|--|--|--|--|--|
| BIRTH NO. 66 04325 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Luther Hosier</u> | | 2. DATE AND HOUR OF DEATH
<u>4/26/66</u> <u>4:45 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>South Baltimore General Hospital</u> | | | | A. STATE <u>Maryland</u> B. COUNTY <u>25-05</u> | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore #21225</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>4201 Pennington Ave.</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Married</u> | | 8. DATE OF BIRTH
<u>10-14-1885</u> | 9. AGE (In years last birthday)
<u>80</u> | 10. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>NONE</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Joseph T. Hosier</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Bella Ann Jones</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Rachel Rupp</u> | |
| | | | | FAMILY | | ADDRESS
<u>Same</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>286.51</u> | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) <u>BRONCHOPNEUMONIA</u>
DUE TO | | <u>4 DAYS</u> | |
| | | | | (B) <u>MALENGITIS +</u>
DUE TO <u>DEHYDRATION</u> | | <u>1 WEEK</u> | |
| | | | | (C) | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>ASCUD</u> | | | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/26</u> 19 <u>66</u> to <u>4/26</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/26</u> 19 <u>66</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Edward A Hoffman</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>4/26/66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Edward S. Hoffman M.D.</u> | | | | 23D. ADDRESS
<u>South Baltimore General Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4 29 66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Parsons</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Salisbury, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 28 1966</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Sisk</u> | | 25C. FUNERAL DIRECTOR
<u>Mc Cully Pat. Ave. & 3rd</u> | | | |

Rachel Rapp
Maryland

Joshua Mosier
None

Married 10-14-1880

421 Pennington Ave

Deborah Rapp

Deborah Rapp
Deborah Rapp

ASCO

Yes

4/24

4/24

4/24

Chad A. Rapp

1

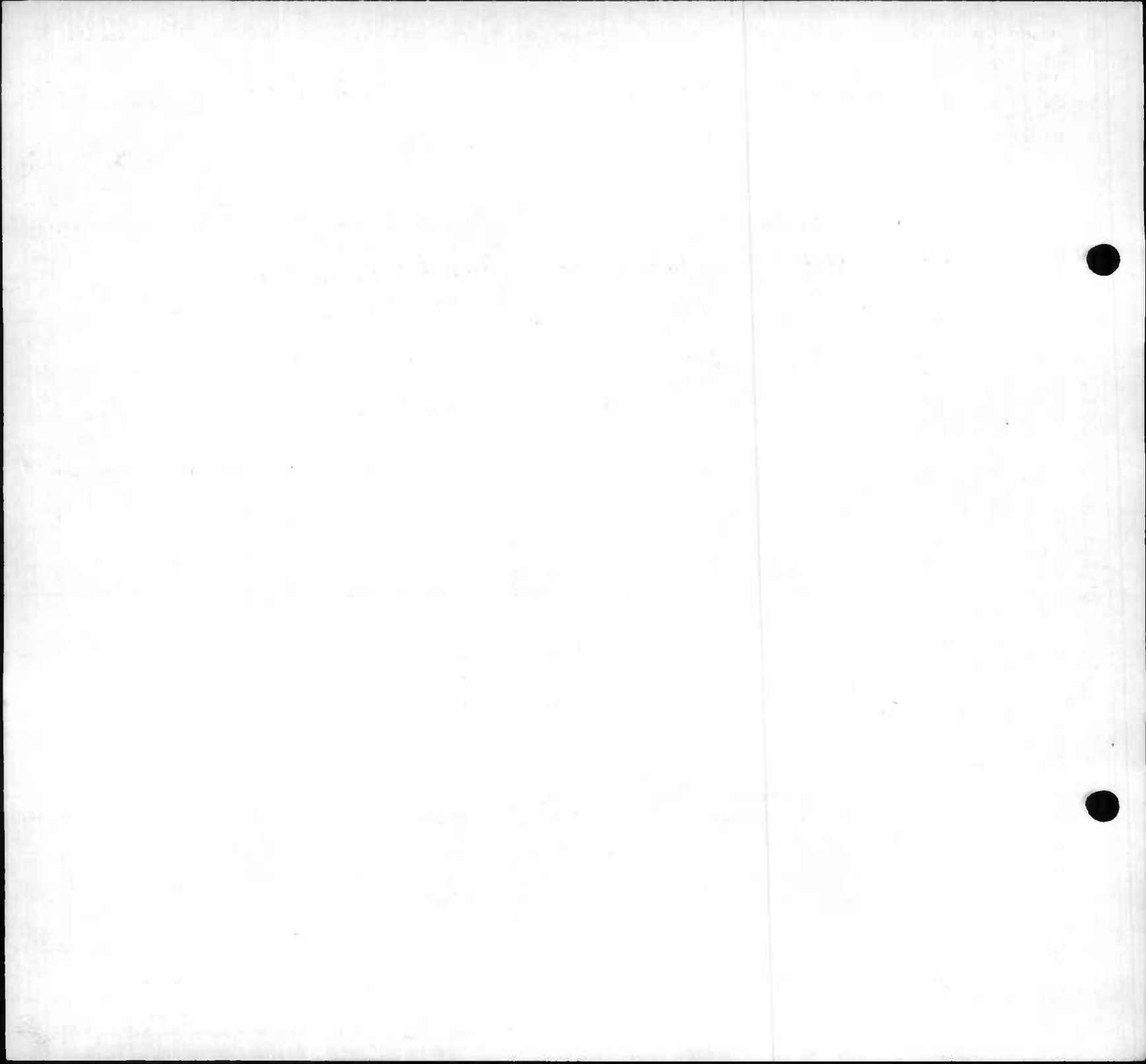
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>66 04326</u> | |
|---|-------------------------|--|-----------------------------------|--|--|--|-----------------------|
| BIRTH NO. <u>66 04326</u> | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Emma K. Long</u> | | | | 2. DATE AND HOUR OF DEATH
<u>4/25/66</u> <u>6A</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
<u>312 S. Norris St.</u> | | | | A. STATE <u>Maryland</u> | | | |
| | | | | B. COUNTY <u>19-03</u> | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>312 S. Norris St.</u> | | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Widowed</u> | 8. DATE OF BIRTH
<u>4/3/77</u> | 9. AGE (In years last birthday)
<u>89</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Charwoman</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Public School</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>George Simmons</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>220-24-6881</u> | | 17. INFORMANT
<u>Effie Berry 3125 Norris St.</u> | | | |
| 18. <u>422.11</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) <u>Arteriosclerotic Cardio-Vascular Disease many years</u>
(B) _____
(C) _____ | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (the hospital) attended the deceased from <u>Jan. 1952</u> to <u>Apr. 25 1966</u> , that (I) (we) last saw the deceased alive on <u>4 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Abraham Goldman</u> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>4. 26. 66</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/28/66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Bedford Hill Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 28 1966</u> | | 25B. NAME OF REGISTRAR
<u>R. B. E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Walters Funeral Home Pratt & Shrike, etc.</u> | | | |



H 524

BALTIMORE CITY HEALTH DEPARTMENT

66 04327

66 04327

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

WILLIAM M. HINKLE

2. DATE AND HOUR PRONOUNCED DEAD

April 25, 1966 4:25 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

902 Light Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 23-02

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

902 Light Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept. 2, 1905

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Ship fitter

10B. KIND OF BUSINESS OR INDUSTRY

Md. Drydock Co.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Hinkle

14. MOTHER'S MAIDEN NAME

Catherine McNamee

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

none

16. SOCIAL
SECURITY NO.

216-09-6294

17. INFORMANT

ADDRESS

Margaret J. Hinkle-902 Light St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Asphyxia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Hanging.
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

902 Light Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
4 25 '66

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Hanged self.

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/26/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/28/66

23C. NAME of CEMETERY or CREMATORY

Holy Cross Cemetery

23D. LOCATION

(City, town, or county)

(State)

Ritchie Highway Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 28 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

KRAUSE FUNERAL HOME 1216 S. Charles St
Balto. Md. 21230

ADDRESS

WALTON BY PRODIGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04328 | |
|---|-------------------------|--|------------------------------------|--|---|
| BIRTH NO. 66 04328 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) SHERMAN QUEEN | | 2. DATE AND HOUR OF DEATH
APRIL 26, 1966 1:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY 25-04 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
CHURCH HOME AND HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location)
524 PATAPSCO AVENUE | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
Widowed | 8. DATE OF BIRTH
8-25-07 | 9. AGE (In years last birthday)
58 | 10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
UNSTODIAN | | 10B. KIND OF BUSINESS OR INDUSTRY
Western Elec Co. | | 11. BIRTHPLACE (State or foreign country)
NORTH CAROLINA | |
| 13. FATHER'S NAME
WILLIAM SHERMAN | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
238-05-1401 | | 17. INFORMANT
Family - 120 Central St. Baltimore | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Portul Anthrax | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
4-20-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Heeding Varices | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED
While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-20-66 to 4-26-66 , that (I) (we) lost saw the deceased alive on 4-26-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Atkins | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Raymond Atkins | | 23D. ADDRESS
Church Home & Hospital | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify)
Burial | | 24B. DATE
4-29-66 | | 24C. NAME OF CEMETERY OR CREMATORY
Green Haven Cem | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Md | | 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1966 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR
McCully & Sons 237 Rutledge Ave 20 | | | |

Hotel Laramie
Laramie, Wyo.
March 1st

Dear Sirs

Enclosed please find

4-20-4

4-20-4

cc

4-20-4

cc

Enclosed

in payment of \$1000

Thank you very much

B. 210

66 04329

BALTIMORE CITY HEALTH DEPARTMENT

66 04329

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT W. BISHOP

2. DATE AND HOUR PRONOUNCED DEAD

April 26, 1966 9:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

779 Carroll Street

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

21-01

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

779 Carroll Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

11-17-13

9. AGE (In years
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

Trucking Co

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George B. Bishop

14. MOTHER'S MAIDEN NAME

Mary Goodman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Joseph Pusinsky

ADDRESS

830 W. Lombard St
Baltimore, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

E 976 X

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot Wound of Head.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

779 Carroll Street

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

4

26

'66

A

m.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self in head.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/26/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4-29-66

23C. NAME of CEMETERY or CREMATORY

Crestmon Cem.

23D. LOCATION

(City, town, or county)

(State)

Howard Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 28 1966

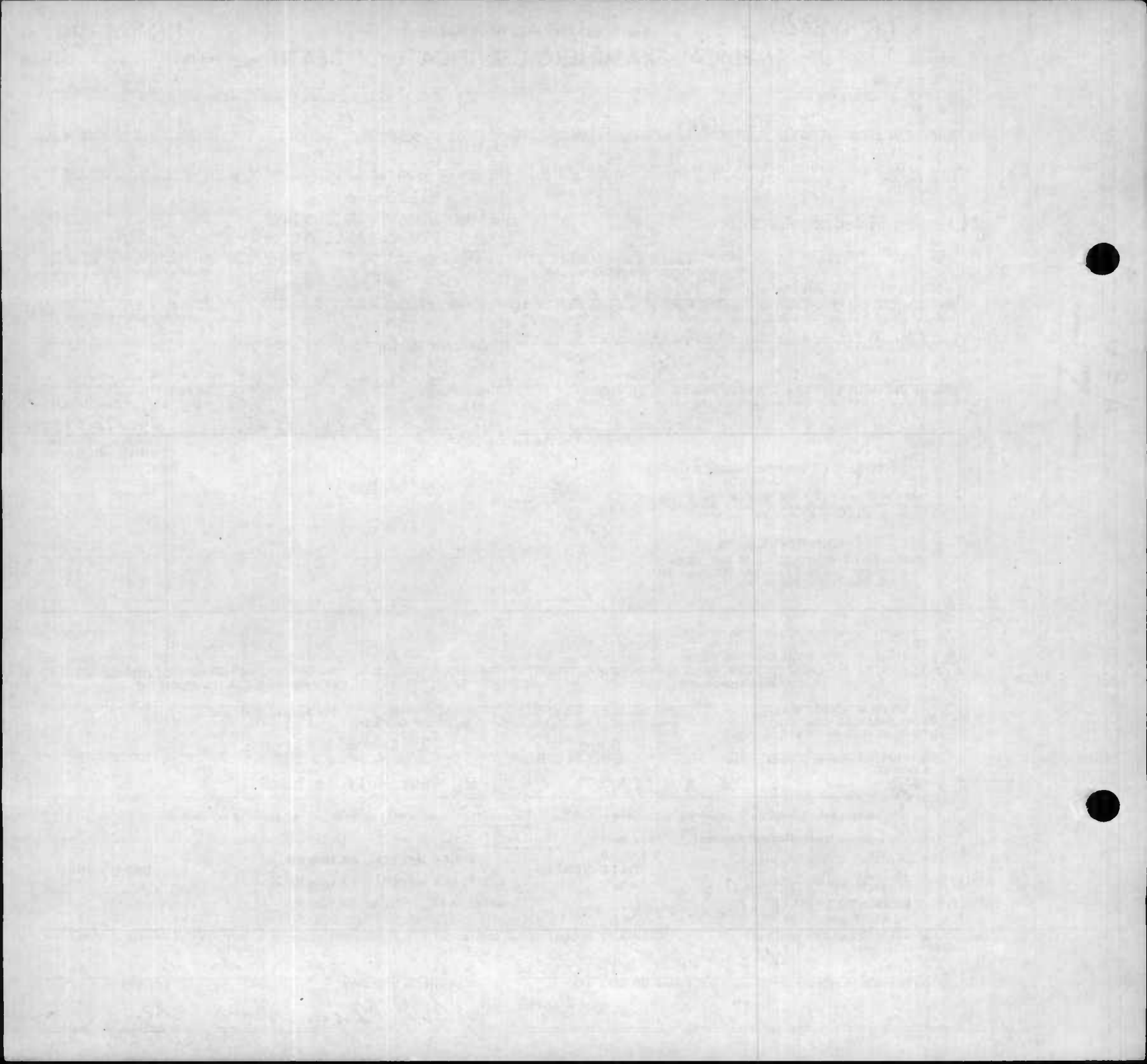
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

John J. Casam + Son Inc.
Baltimore, Md.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|--|--|
| BIRTH NO. 66 04330 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04330 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Elizabeth M. Kelly | | 2. DATE AND HOUR OF DEATH
4-26-66 12:50 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 11-03 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
South Baltimore General Hosp. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore #21202 | | | |
| D. STREET ADDRESS (If rural, give location)
730 N. Howard St. | | 5. SEX F | | 6. RACE White | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Widow | | 8. DATE OF BIRTH
12-20-83 | | 9. AGE (In years last birthday)
82 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Balto., Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Patrick McNaney | | 14. MOTHER'S MAIDEN NAME
Catherine Branch | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mr. Harry Kelly | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ASCVD | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 4-25 1966 to 4-26 1966, that (we) last saw the deceased alive on 4-26 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
V. Albertson, M.D. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4-26-66 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. V. Albertson | | 23D. ADDRESS
SOUTH BALTIMORE GENERAL HOSPITAL
1213 Light Street, Balto., Md. 21230 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4 29 66 | | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral | |
| 24D. LOCATION
Balto., Md. | | 24E. LOCATION
(City, town, or county) | | 24F. LOCATION
(State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1966 | | 25B. NAME OF REGISTRAR
Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR
J. Kelly | |
| | | | | ADDRESS
130 E. Fort Ave | |

Elmwood St. Kelly

4-20-60

12:00 PM

South Baltimore General Hosp

F white widow

None

Patrick McManey

12-20-60

Balto, Md

Catherine Branch

730 N. Howard St

Baltimore 21205

Maryland

Yes

4-20-60

4-20-60

cc

4-20-60

✓

4-20-60

High

1
W 450

66 04331

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04331

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANNA L. WILLINE

2. DATE AND HOUR PRONOUNCED DEAD

April 26, 1966 3:45 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore Dundalk

D. STREET ADDRESS (If rural, give location)

8110 Bletzer Road 21222

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

March 28 1914

9. AGE (In years last birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Frank Schultz Sr.

14. MOTHER'S MAIDEN NAME

Barbara Moravec

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL SECURITY NO.

220-03-6226

17. INFORMANT

ADDRESS

Husband, Mr. Henry W. Willine, # 4,a,b,c,d.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Cirrhosis.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED
4/26/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

April 29-1966

23C. NAME of CEMETERY or CREMATORY

Parkwood Cemetery

23D. LOCATION (City, town, or county)

Taylor Ave. Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 28 1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

JOHN J. DUDA, Dundalk, Maryland 21222

ADDRESS

WALLLEY BORDERS

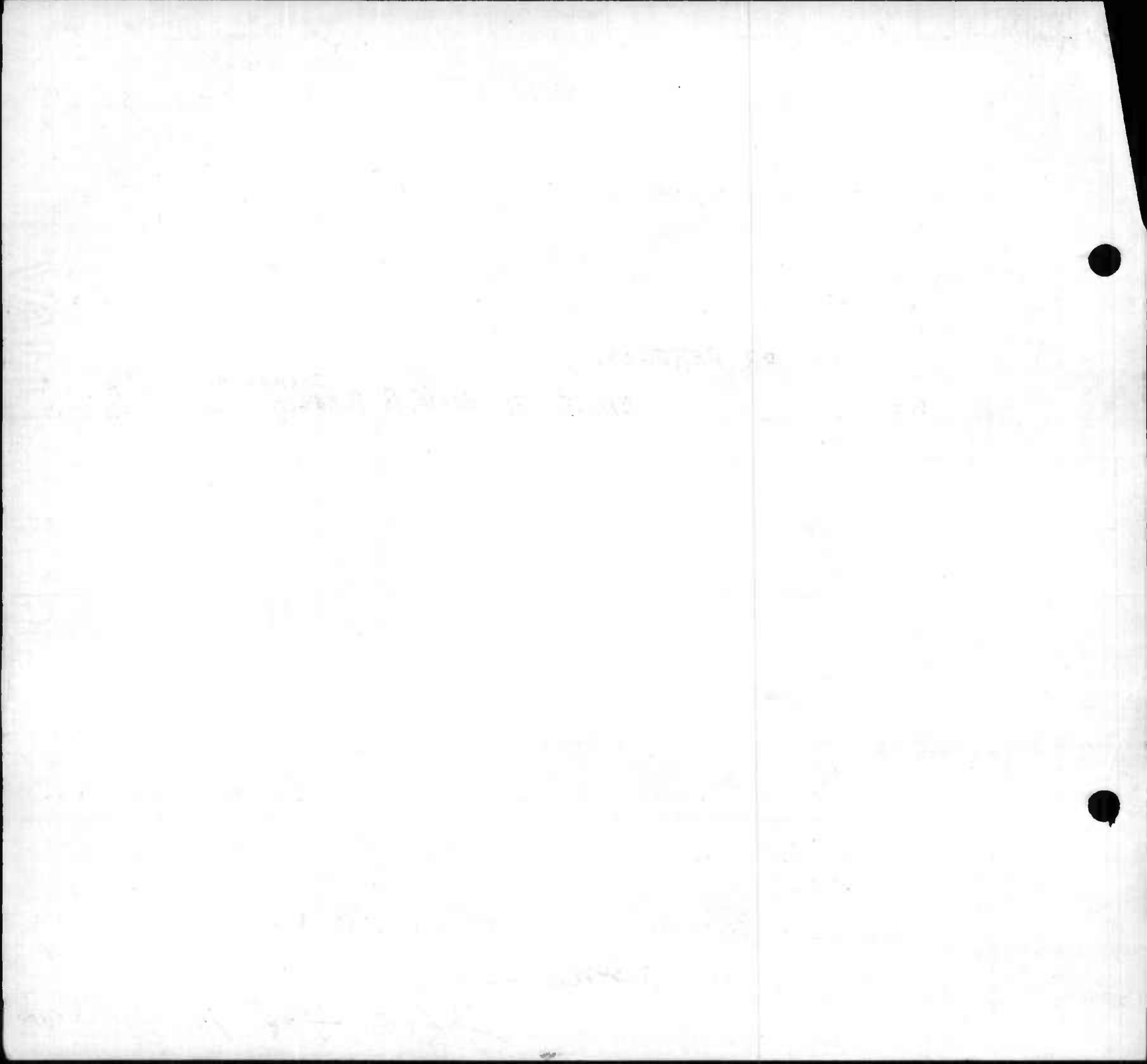
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04332 | |
|--|---------------------|---|---|--|---|
| BIRTH NO. 66 04332 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Percey, Leray ARMACOST</i> | | 2. DATE AND HOUR OF DEATH
<i>April 25, 1966 4:30 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>University Hospital</i> | | | A. STATE <i>Maryland</i> B. COUNTY <i>Carroll</i> | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Hamstead 5600</i> | | |
| | | | D. STREET ADDRESS (If rural, give location)
<i>306 Hocksville Rd</i> | | |
| 5. SEX
<i>M</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Married</i> | 8. DATE OF BIRTH
<i>7/12/07</i> | 9. AGE (In years last birthday)
<i>58</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>bus driver</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Baltimore Co Bd of Educ</i> | | 11. BIRTHPLACE (State or foreign country)
<i>MD</i> | |
| 13. FATHER'S NAME
<i>Nechor PEREGY</i> | | | 14. MOTHER'S MAIDEN NAME
<i>Viola Bauber</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>214-28-0481</i> | | 17. INFORMANT
<i>306 Hocksville Rd</i>
<i>NELLIE R. PEREGY HAMSTEAD MD</i> | |
| 18. <i>202/1</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) <i>Pulmonary Embolism</i>
DUE TO
(B) <i>Lymphoma suspected</i>
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<i>3 days</i>
<i>6 weeks</i> |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>April 8</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Laparotomy</i> | | 20A. AUTOPSY? (Yes or No)
<i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>April 20, 1966</i> to <i>April 25, 1966</i> , that (I) (we) last saw the deceased alive on <i>April 25, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Harold C Standiford</i> | | | | 23B. DATE SIGNED
<i>4/26/66</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>HAROLD C STANDIFORD</i> | | | | 23D. ADDRESS
<i>University Hosp. BALTO, MD</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 24B. DATE
<i>4/29/66</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>FORESTON CEMETERY</i> | |
| | | 24D. LOCATION (City, town, or county) (State)
<i>PARKTON, MD</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>APR 28 1966</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Farber</i> | | 25C. FUNERAL DIRECTOR
<i>John E. Hoff</i> | |
| | | | | ADDRESS
<i>Hamstead, MD</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

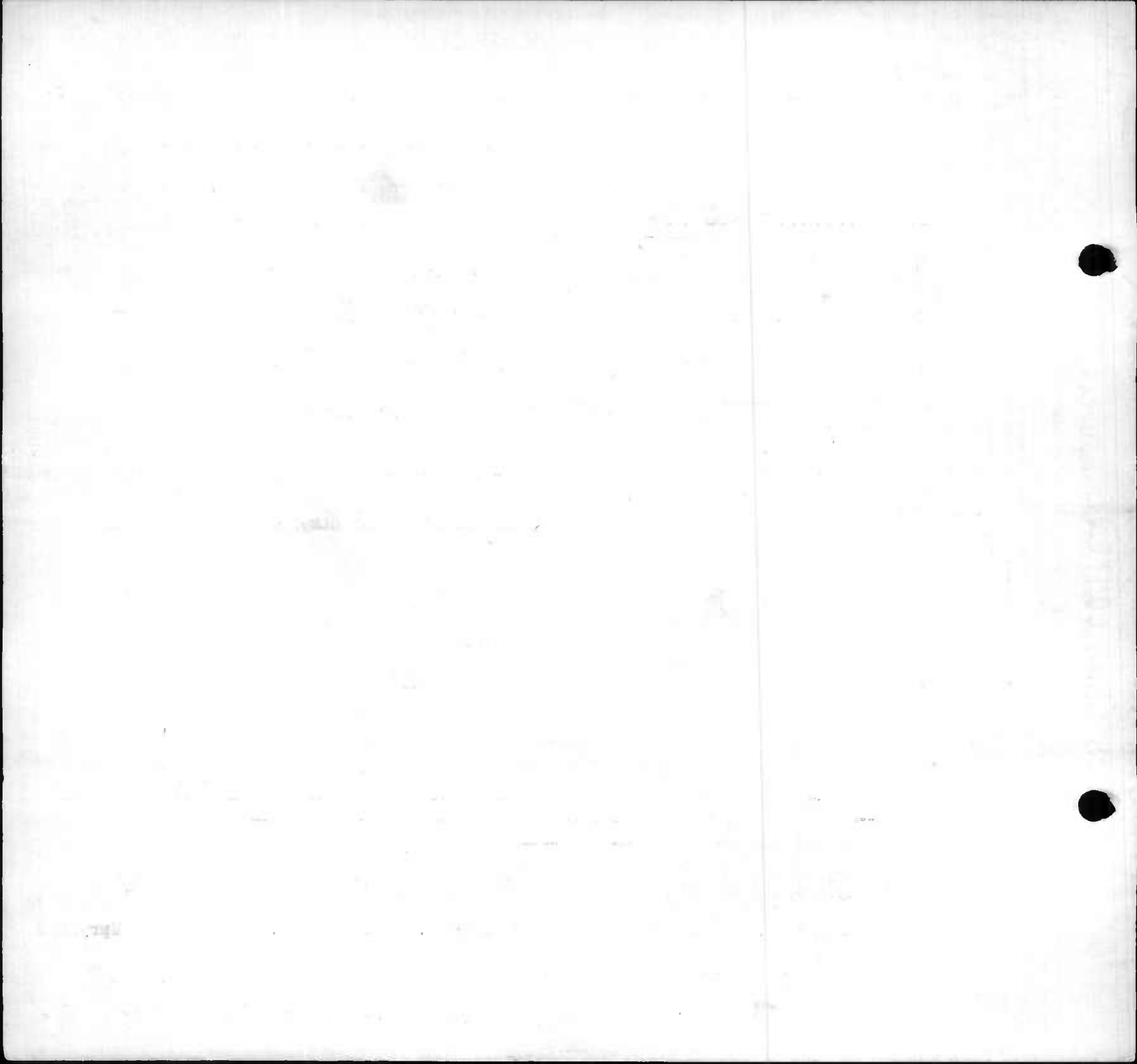
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 66 04333

| | | | | | |
|---|---------------------|---|---|--|--|
| BIRTH NO. <u>66 04333</u> | | 1. NAME OF DECEASED
(Type or Print) <u>Stan S. Strosburger</u> | | 2. DATE AND HOUR OF DEATH
<u>April 25, 1966</u> <u>120</u> P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Bolton Hill Nursing and Convalescent Center</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Anderson Nursing Home</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore Md.</u>
D. STREET ADDRESS (If rural, give location) <u>Mohawk Ave. - 3604</u> | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED NEVER MARRIED
<u>WIDOWED</u> , DIVORCED (specify) | 8. DATE OF BIRTH
<u>5/10/1875</u> | 9. AGE (In years last birthday)
<u>90</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Salesman</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>BALTO. MD</u> | |
| 13. FATHER'S NAME
<u>Victor C. Strosburger</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Sallie Stern</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>216-09-3901</u> | | 17. INFORMANT
<u>Mrs. D. Zitz K.N.</u> | |
| 18. <u>420.1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

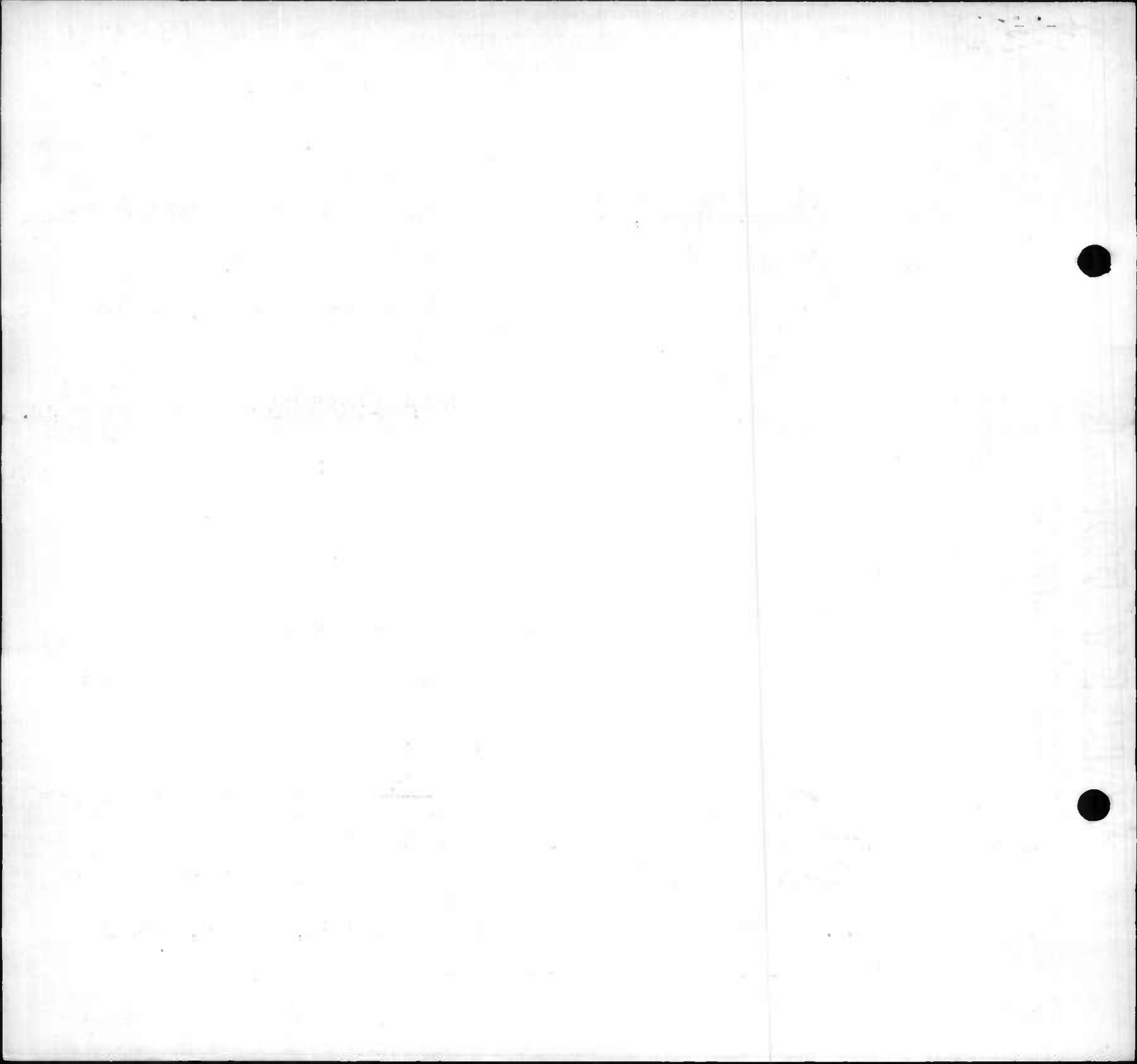
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) <u>Coronary Thrombosis</u>
(B) <u>arteriosclerotic Heart Disease</u>
(C) | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u>
<u>20 years</u> |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>None</u> | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>(u)</u> (this hospital) attended the deceased from <u>January 10</u> 19 <u>66</u> to <u>April 25</u> 19 <u>66</u> , that (I) <u>(u)</u> last saw the deceased alive on <u>April 24</u> 19 <u>66</u> and that in (my) <u>(u)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(u)</u> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Stanley Z. Felsenberg</u> | | | | 23B. DATE SIGNED
<u>4/25/66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Stanley Z. Felsenberg</u> | | 23D. ADDRESS
M.D. <u>1129 E. Baltimore St. Baltimore 2, Maryland</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>CREMATION</u> | | 24B. DATE
<u>4/27/1966</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>GREENMOUNT</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>BALTO MD</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 28 1966</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Stanley Z. Felsenberg</u> | | 25C. FUNERAL DIRECTOR
<u>SYLVAN J. LEWIS + SON - 3319 Olympic Ave</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 04334</u> | |
|--|-----------------------------|---|------------------------------------|--|--|
| BIRTH NO. <u>66 04334</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>NICOLA PASTORE</u> | | 2. DATE AND HOUR OF DEATH
<u>4-26-66</u> <u>1:15</u> P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>BALTO City Hosp.</u>
<u>4940 Eastern Avenue, Baltimore, Maryland</u> | | A. STATE <u>MD</u> B. COUNTY <u>BALTO</u> <u>26-36</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTO</u> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>1308 S. BETHHEM AVE 21224</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>WIDOWED</u> | 8. DATE OF BIRTH
<u>6-26-82</u> | 9. AGE (In years last birthday)
<u>83</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Cement work</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>ITALY</u> | |
| 13. FATHER'S NAME
<u>?</u> | | 14. MOTHER'S MAIDEN NAME
<u>?</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>?</u> | | 17. INFORMANT
<u>Mrs. J. Record</u>
Records: BCH-4940 Eastern Avenue, Baltimore, Md. | |
| 18. <u>422.1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>ASCVD</u> | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>POSSIBLE PNEUMONIA</u> | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
<u>Yes</u> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>HT</u> (this hospital) attended the deceased from <u>3-29-66</u> to <u>4-26-66</u> , that <u>HT</u> (we) last saw the deceased alive on <u>4-26-66</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>HT</u> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>J. E. Randall</u> M.D. | | | | 23B. DATE SIGNED
<u>4-26-66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>J. E. Randall</u> | | 23D. ADDRESS
M.D. <u>4940 Eastern Avenue, Baltimore, Maryland</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | 24B. DATE
<u>4-29-66</u> | 24C. NAME of CEMETERY or CREMATORY
<u>St Stanislaus Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 28 1966</u> | | 25B. NAME OF REGISTRAR
<u>R. E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Walter Dabrowski 1005 Dundalk Avenue</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>66 04335</u> | |
|--|-------------------------|--|------------------------------------|---|------------------------------|--|--|
| BIRTH NO. <u>66 08973</u> | | M.E. CASE NO. <u>66 04335</u> | | 1. NAME OF DECEASED
(Type or Print) <u>GOLPHIN, girl - A</u> | | 2. DATE AND HOUR OF DEATH
<u>4/26/66</u> <u>1:40</u> A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
<u>JOHNS HOPKINS HOSPITAL</u>
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>10-02</u> | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>911 N. VALLEY STREET</u> | | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>Never married</u> | 8. DATE OF BIRTH
<u>4/25/66</u> | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months: Days | 11. Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>N.A.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>N.A.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<u>LOUIS GOLPHIN</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>EDITH CHEEKS</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 18. <u>771.51</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>Prematurity</u>
(A) DUE TO | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
<u>16 hours</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Hyaline membrane Disease</u>
(B) DUE TO | | | | | | <u>14 hours</u> | |
| | | | | <u>pulmonary hemorrhage (probable)</u>
(C) | | <u>7.2 hours</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<u>None</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<u>NO</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<u>None</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <u>4/25</u> 19 <u>66</u> to <u>4/26</u> 19 <u>66</u> , that (I) <u>we</u> last saw the deceased alive on <u>4/25</u> 19 <u>66</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> <u>did</u> (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Robert S. Thompson</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>4/26/66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>ROBERT S. THOMPSON</u> | | | | 23D. ADDRESS
M.D. <u>609 North Caroline St.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>cremation</u> | | 24B. DATE
<u>4-26-66</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>The Johns Hopkins Hospital Baltimore, Maryland</u> | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 28 1966</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR | | ADDRESS | |

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Handwritten text in the middle section of the page.

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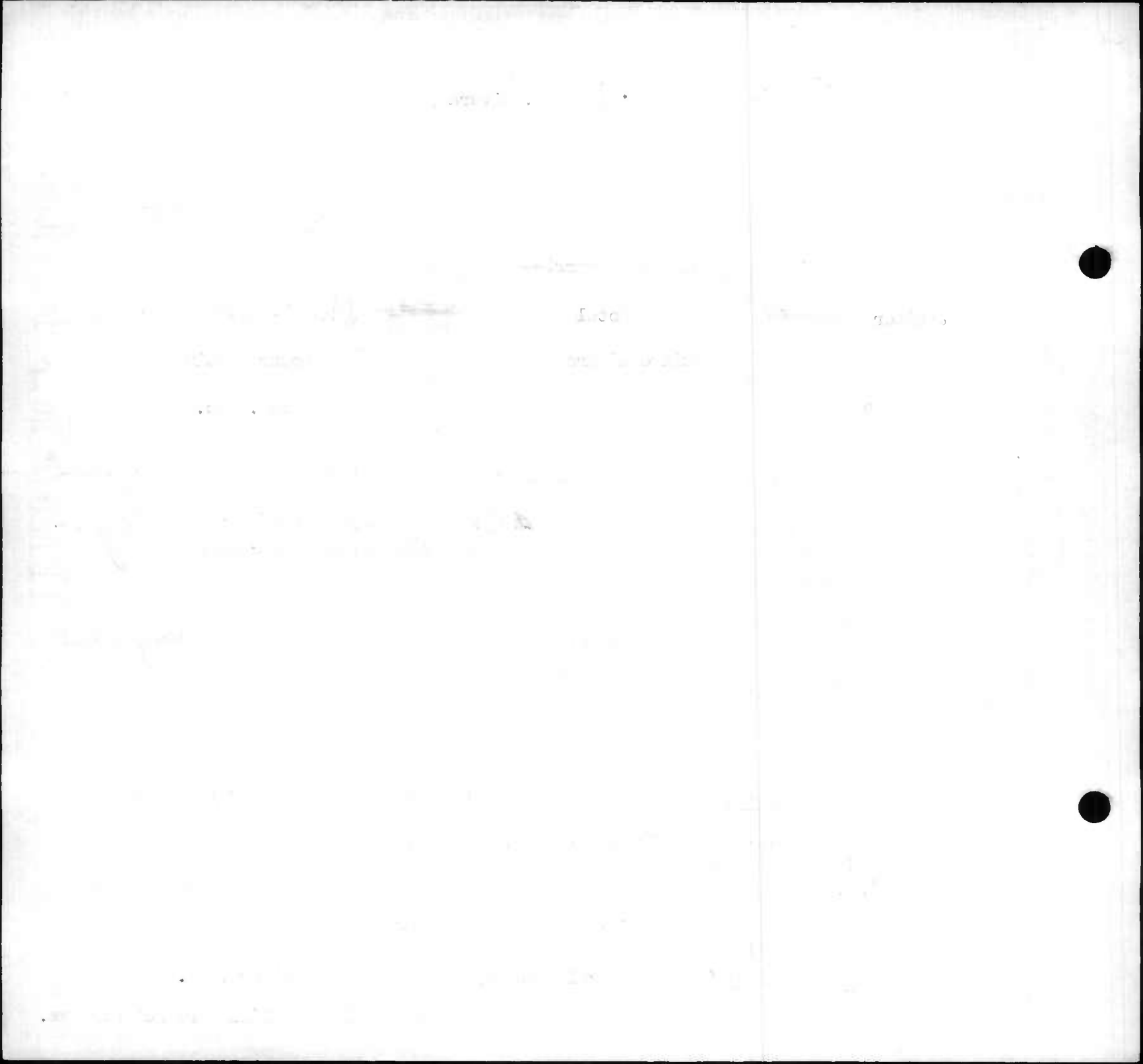
Handwritten text at the bottom of the page, possibly a conclusion or signature.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|--------------------------------|--|---|
| BIRTH NO. R160 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04336 | |
| M.E. CASE NO. 66 04336 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Ortiz, José R. (Also known as Jose R. Rivera) | | 2. DATE AND HOUR OF DEATH
4-26-66 6 15 A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

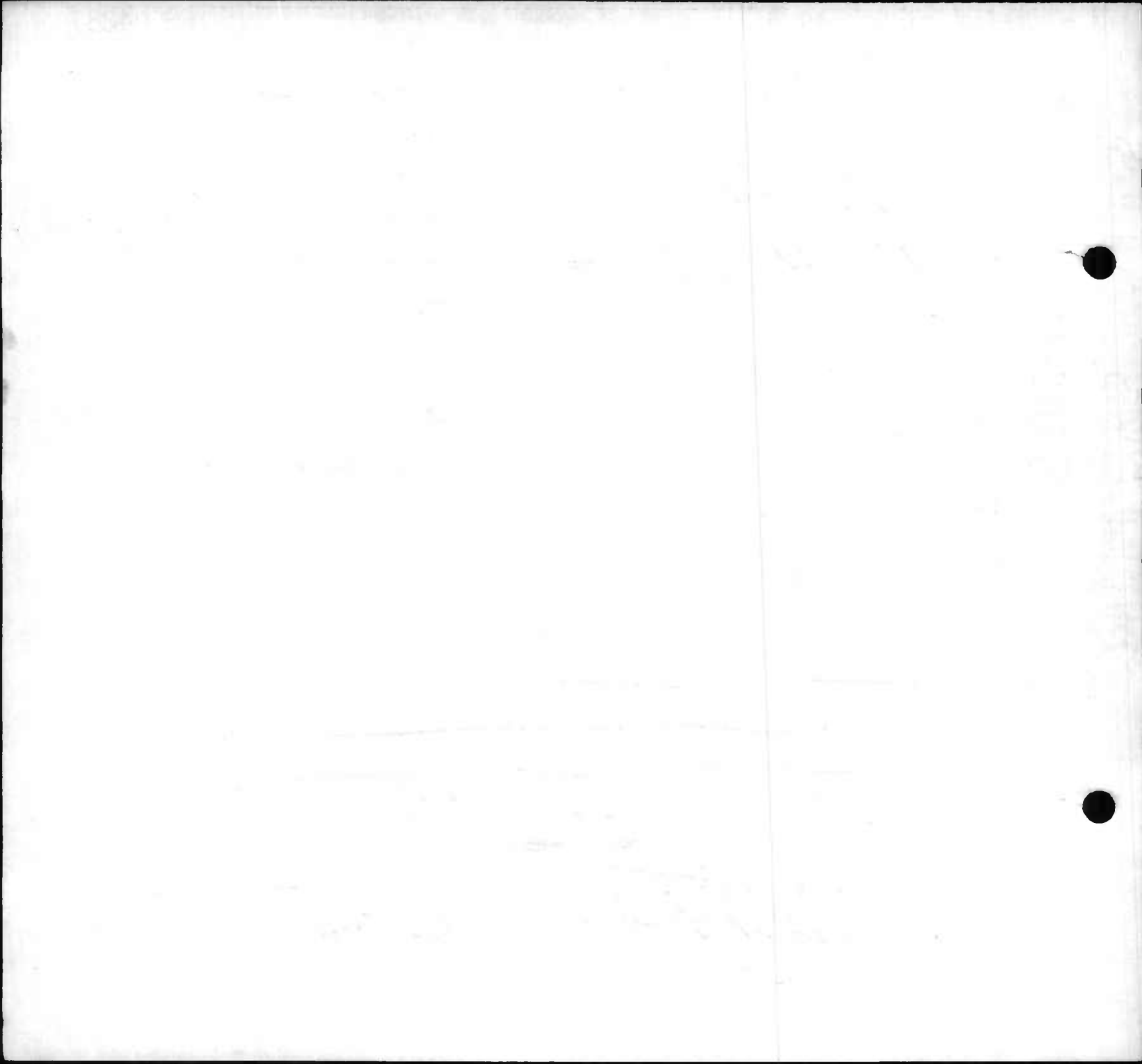
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSP OF BALTO | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 2706 Springhill Ave #15 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED Married | 8. DATE OF BIRTH 3/8/88 | 9. AGE (In years last birthday) 78 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor | | 10B. KIND OF BUSINESS OR INDUSTRY Hotel | | 11. BIRTHPLACE (State or foreign country) Puerto Rico | |
| 13. FATHER'S NAME Isidro Rivera | | 14. MOTHER'S MAIDEN NAME Romard Ortiz | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Hosp. Rec. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)
Chronic Renal disease | | CAUSE OF DEATH
(A) DUE TO Chronic obstructive Airway disease | | INTERVAL BETWEEN ONSET AND DEATH
Many years | |
| 18. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
ASCVD | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) none | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/13/66 19 to 4/26/66 19, that (I) (we) lost saw the deceased alive on 4/25/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE HARRY M WALEN M.D. | | | | 23B. DATE SIGNED 4-26-66 | |
| 23C. PHYSICIAN'S NAME (Type) HARRY M WALEN | | | | 23D. ADDRESS SINAI HOSP | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4/28/66 | | 24C. NAME OF CEMETERY or CREMATORY Cathedral Cemetery | |
| 24D. LOCATION (City, town, or county) Baltimore, Md. | | (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 26 1966 | | 25B. NAME OF REGISTRAR R. E. Jenkins | | 25C. FUNERAL DIRECTOR ADDRESS B. Vernon Lemmon 4611 Park Heights Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|-----------------------------------|---|--|
| 66 04337 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04337 | |
| BIRTH NO. 355601 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>McAbee, Clayton</i> | | 2. DATE AND HOUR OF DEATH
<i>4-27-66</i> <i>1:55 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>MD</i> B. COUNTY <i>15-10</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>42 Sinai Hosp</i> | | D. STREET ADDRESS (If rural, give location)
<i>4023 Bogeman Ave.</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>N</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
<i>widowed</i> | 8. DATE OF BIRTH
<i>3-7-94</i> | 9. AGE (In years last birthday)
<i>72</i> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>janitor</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Pa</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>US</i> | | 13. FATHER'S NAME
<i>unknown</i> | | 14. MOTHER'S MAIDEN NAME
<i>unknown</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Gladys Randall</i> ADDRESS <i>2319 Arundel Ave</i> | |
| 18. <i>592X I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <i>Chronic renal disease ? etiology</i>
DUE TO
(B) _____
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<i>?</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<i>Remarks</i> | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>?</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from <i>4-25</i> 19 <i>66</i> to <i>4-27</i> 19 <i>66</i> , that (I) was last saw the deceased alive on <i>4-27</i> 19 <i>66</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Leonard J. Hertzberg</i> M.D. | | 23B. DATE SIGNED
<i>4-27-66</i> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Leonard J. Hertzberg</i> M.D. | | 23D. ADDRESS
<i>Sinai Hosp. Balt., Md</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>4-28-66</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Arbutus Mem Pk</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Baltimore Md</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>APR 28 1966</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Farley</i> | | 25C. FUNERAL DIRECTOR
<i>1011-13 Sullivan Funeral Home - N. Arlington Ave</i> | |



1
H 252

66 04338

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04338

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CORETHA M. HAWKINS

2. DATE AND HOUR PRONOUNCED DEAD

April 25, 1966 6:50 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2019 E. North Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2019 E. North Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

8/27-07

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

STOCK MAID

10B. KIND OF BUSINESS OR INDUSTRY

HUTZLER

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

RICHARD D. SMITH

14. MOTHER'S MAIDEN NAME

MARION THOMAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RAIPH OTTO HAWKINS 20196 North

| 18. CAUSE OF DEATH | | INTERVAL BETWEEN
ONSET AND DEATH |
|---|--|-------------------------------------|
| DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.) | | |
| (A) Asphyxia
DUE TO | | |
| (B) Hanging.
DUE TO | | |
| (C)..... | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT. | | |

MEDICAL CERTIFICATION

| | | | |
|--|--|--|---|
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? |
| 0 | | No | |
| 21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) | 21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | Home | 2019 E. North Avenue | |
| 21D. TIME
OF INJURY
(APPROX.) | (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
| | 4 25 '66 P | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | Hanged self. |

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/26/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

4/29/66

23C. NAME OF CEMETERY or CREMATORY

mt. Calvary

23D. LOCATION

(City, town, or county)

O. O. County, Md

24A. DATE REC'D BY HEALTH DEPT.

APR 28 1966

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Joseph L. Rock, 1304 N. Central

ADDRESS

WALLLEY FORGE

R&B BOYNTON

U.S.A.

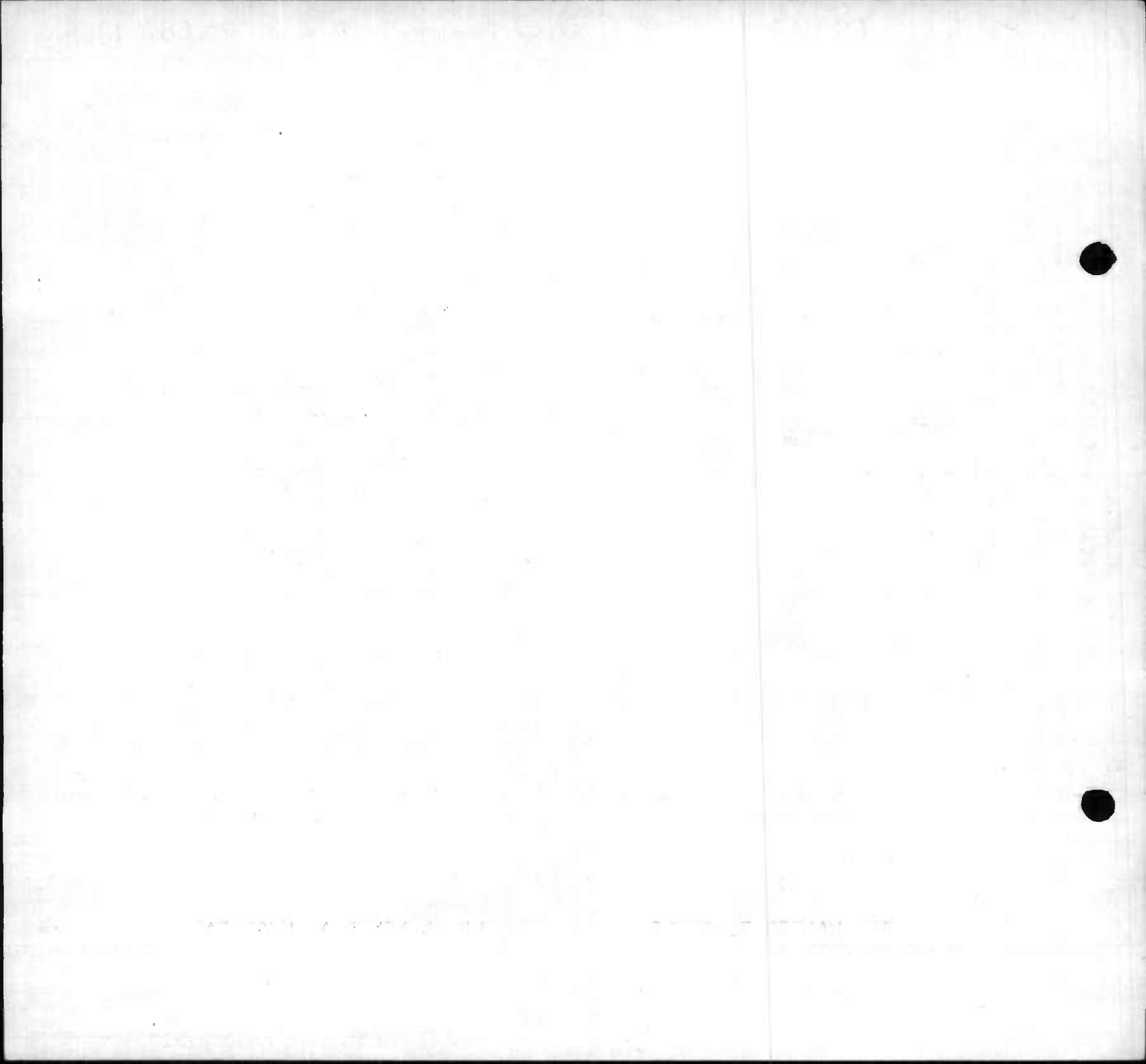
1-2-77

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|--|--|---|--|---|--|--|--|
| BIRTH NO. 66 04339 | | | | | REGISTERED NO. 66 04339 | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print)
LEROY LEWIS THOMPSON | | | | | 2. DATE AND HOUR OF DEATH
4/26/66 5:05 P. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
44 Union Memorial Hosp | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2811 Montebello Terrace | | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Married | 8. DATE OF BIRTH
6/23/04 | 9. AGE (In years last birthday)
61 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Returned Dispatcher | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
John P. Thompson | | | 14. MOTHER'S MAIDEN NAME
Ethel Beene | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | |
| 16. SOCIAL SECURITY NO.
214 01-5746 | | | 17. INFORMANT
Mrs Ruth E. Thompson | | | | ADDRESS
2811 Montebello Terrace 21214 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Pulmonary Emphysema | | | | | INTERVAL BETWEEN ONSET AND DEATH
DMC | | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
DMC | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
— | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
— | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
— | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
— | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work
— | | 21F. HOW DID INJURY OCCUR?
— | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 18 19 66 to April 26 19 66 , that (I) (we) last saw the deceased alive on April 26 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (He) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
W. T. Boone (DMC) (grave marker) | | | | | 23B. DATE SIGNED
4/26/66 | | | 23C. PHYSICIAN'S NAME (Type)
DR. WALTER T. BOONE | |
| 23D. ADDRESS
UNION MEMORIAL HOSPITAL | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/29/66 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1966 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
HENRY SANDER & SONS INC. BALTIMORE MARYLAND 21213 | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N 550 1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 04340

BIRTH NO.

66 04340

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

NEWMAN, ROBERT

2. DATE AND HOUR OF DEATH

4-27-66

4:40 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

LUTHERAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

15-48

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2111 GARRISON BLVD #16

5. SEX

M

6. RACE

N

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

4-19-1900

9. AGE (In years last birthday)

66

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

TRUCK DRIVER

10B. KIND OF BUSINESS OR INDUSTRY

?

11. BIRTHPLACE (State or foreign country)

SOUTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

YES

WWI

16. SOCIAL SECURITY NO.

217-16-4480

17. INFORMANT RUTH NEWMAN

ADDRESS

WIFE - 2111 GARRISON BLVD.

18.

434.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) PULMONARY EDEMA

DUE TO

(B) CHRONIC HEART DISEASE

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

?

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-27 1966 to 4-27 1966, that (I) (we) last saw the deceased alive on 4-27 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Artemio M. Cuevas, Jr.

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

4-27-66

23C. PHYSICIAN'S NAME (Type)

ARTEMIO M. CUEVAS, JR.

M.D.

23D. ADDRESS

LUTHERAN HOSPITAL, BALT. MD

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4-30-66

24C. NAME OF CEMETERY OR CREMATORY

mt Auburn

24D. LOCATION

Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.

APR 28 1966

25B. NAME OF REGISTRAR

E. E. Taylor

25C. FUNERAL DIRECTOR

2302 W. North Ave Baltimore

ADDRESS

WE LUTHERAN

LUTHERAN HOSPITAL

MARRIED

TRUCK DRIVER

YES

ROBERT

4-27-66

4-27-66

MARYLAND

BALTIMORE

211 GARRISON BLVD. N.W.

4-19-1900

SOUTH CAROLINA

U.S.A.

WIFE

211 GARRISON BLVD.

PULMONARY EDEMA

CHRONIC HEART DISEASE

ARTURO M. CUEVAS, JR.

Signature

4-27-66

4-27-66

4-27-66

4-27-66

*

4-27-66

LUTHERAN HOSPITAL

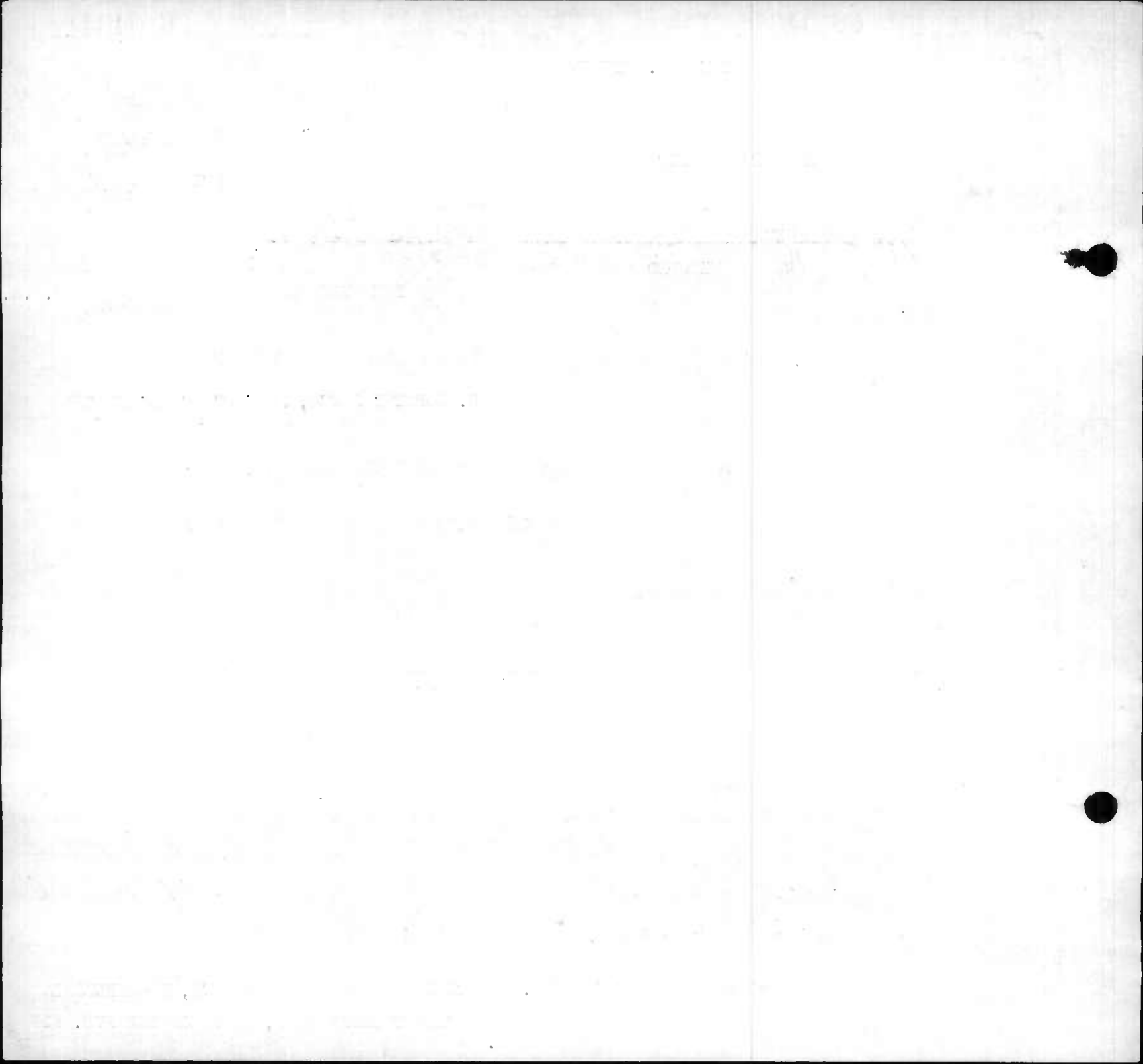
BALTIMORE

211 GARRISON BLVD.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04341 | |
|---|--|---|--|--|--|
| BIRTH NO. 66 04341 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) PETER W. DINKEL | | 2. DATE AND HOUR OF DEATH
24 APR. 66 8:25 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN BALTO. D. STREET ADDRESS (If rural, give location) 3210 EVERGREEN AVENUE | | 5. SEX MALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL | | 8. DATE OF BIRTH 3-21-88 9. AGE (In years last birthday) 78 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST | | 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CHRISTOPHER DINKEL | | 14. MOTHER'S MAIDEN NAME MARGARET FRANZ | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | |
| 16. SOCIAL SECURITY NO. - | | 17. INFORMANT ADDRESS MRS. DOROTHY JUDGE, 3210 EVERGREEN AVENUE | | 18. CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
154X I | | (A) METASTATIC CARCINOMA | | INTERVAL BETWEEN ONSET AND DEATH 2 YRS. | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) CARCINOMA OF RECTUM | | 3 YRS. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) - | | | |
| 19A. DATE OF OPERATION 2 1963 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA OF RECTUM | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-25 1966 to 4-25 1966 , that (I) (we) last saw the deceased alive on 4-25 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Ward Kurad | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 24 Apr. '66 | |
| 23C. PHYSICIAN'S NAME (Type) J. WARD KURAD | | 23D. ADDRESS UNIV. HOSP. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 4-28-66 | | 24C. NAME OF CEMETERY or CREMATORY PITTSTON AVE. CEMETERY | |
| 24D. LOCATION (City, town, or county) LACKAWANNA COUNTY, PENNSYLVANIA | | 24E. (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 28 1966 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS HUBBARD FUNERAL HOME, 4107 WILKENS AVE. #29 | |



M 460

66 04342

BALTIMORE CITY HEALTH DEPARTMENT

66 04342

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH E. MILLER

2. DATE AND HOUR PRONOUNCED DEAD

4-25-66

6:05 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

NAME OF HOSPITAL OR INSTITUTION
ADDRESS OR LOCATION

Baltimore City Hospitals
4940 Eastern Avenue, Baltimore 21224

4. USUAL RESIDENCE (Where deceased lived, If institution residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Ellicott City

D. STREET ADDRESS (If rural, give location)

Horseshoe Road 21042

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

9-11-95 96

9. AGE (In years
last birthday)

70 69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETAIL SALES OFFICE

10B. KIND OF BUSINESS OR INDUSTRY

MARYLAND STATE

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HENRY MILLER

14. MOTHER'S MAIDEN NAME

Anna Scheffel

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

W W I

16. SOCIAL
SECURITY NO.

219-07-2813

17. INFORMANT

MRS. MARIE M. BUCKMASTER, 132 N. GROVE

RECORDS: BCH 4940 Eastern Ave., 21224 ANGLE RD

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)

(A) Bronchopneumonia and uremia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Chronic pyelonephritis
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Fracture right hip

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Parapsco Ave., & Washington Boulevard

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)
4 16 '66 11:40

21E. INJURY OCCURRED

WHILE AT
WORK

NOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Ambulance-auto collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

4-25-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

4-27-66

23C. NAME of CEMETERY or CREMATORY

BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 28 1966

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

HUBBARD FUNERAL HOME, 4107 WILKENS AVE. #29

Letter from RSE - 6/2/66

CERTIFICATE AMENDED

WALTER H. FORGE

MEMORANDUM

X

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 66 04343 | |
|--|---------------------|--|--|--|---|---|---|
| BIRTH NO. 66 04343 | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) HILTON, MARION | | | | 2. DATE AND HOUR OF DEATH
4/26/66 8 25 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
2 SINAI HOSPITAL OF BALTIMORE, INC | | (If not in hospital or institution, give street address or location) | | A. STATE
MARYLAND | | B. COUNTY
BALTIMORE CITY | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | 27-18 | |
| | | | | D. STREET ADDRESS (If rural, give location)
5315 BEAUFORT AVE | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
2/14/1896 | 9. AGE (In years last birthday)
70 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Charles C. Musgrave | | | 14. MOTHER'S MAIDEN NAME
Laura V. Easton | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
412-18-5809 | | 17. INFORMANT ADDRESS
Mr. Charles Hilton-5315 Beaufort Ave. -15 | | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Acute Myocardial Infarction | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
2 Hours | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | | |
| | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1946 to 4/26 19 66 , that (I) (we) last saw the deceased alive on 4/26 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Edward S. Kallins | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/26/66 | |
| 23C. PHYSICIAN'S NAME (Type)
Edward S. Kallins | | | | 23D. ADDRESS
4300 LIBERTY AVE BY BALTIMORE 7 MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/30/66 | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State)
3801 Frederick Ave. Balt. 29, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1966 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
Loring Byers-8728 Liberty Rd. Randallstown | | | |

ATTORNEY GENERAL

UNITED STATES OF AMERICA
v.
JAMES EARL RAY

MEMORANDUM

F. W.

2/11/68

RE: JAMES EARL RAY

RE: JAMES EARL RAY

1968

1968

1968

James Earl Ray

James Earl Ray

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--|-----------------------------|--|---|---|---|---|--|--|
| BIRTH NO. 66 04344 | | | | | CERTIFICATE OF DEATH | | | Registered No. 66 04344 | |
| <div style="display: flex; justify-content: space-between;"> <div> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) Thomas L. Hofferbert</p> </div> <div> <p>2. DATE AND HOUR OF DEATH</p> <p>4/24/66. 5pm</p> </div> </div> | | | | | | | | | |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p>BALTIMORE CITY HOSPITALS
 4940 Eastern Avenue
 Baltimore, Maryland 21224</p> | | | | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE MARYLAND B. COUNTY BALTIMORE</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Essex</p> <p>D. STREET ADDRESS (If rural, give location) Box 399 1/2 Evergreen Park - 21224 (21)</p> | | | | |
| <p>5. SEX MALE</p> | | <p>6. RACE WHITE</p> | | <p>7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED</p> | | <p>8. DATE OF BIRTH 5/30/09</p> | | <p>9. AGE (In years last birthday) 56</p> | |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman</p> | | | <p>10B. KIND OF BUSINESS OR INDUSTRY
Insurance</p> | | | <p>11. BIRTHPLACE (State or foreign country)
MARYLAND, Baltimore</p> | | <p>12. CITIZEN OF WHAT COUNTRY?
U.S.A.</p> | |
| <p>13. FATHER'S NAME
JOHN Hofferbert</p> | | | | | <p>14. MOTHER'S MAIDEN NAME
Margaret MEHRING</p> | | | | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO</p> | | | <p>16. SOCIAL SECURITY NO.</p> | | <p>17. INFORMANT ADDRESS
RECORDS: BCH 4940 EASTERN AVE, BALTO. MD. 21224</p> | | | | |
| <p>18. 420.1 I</p> <p style="text-align: center;">CAUSE OF DEATH</p> <div style="display: flex; justify-content: space-between;"> <div> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;">ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div> <p>(A) DUE TO acute MI</p> <p>(B) DUE TO ASCVD</p> <p>(C) _____</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p>18 hrs</p> <p>years</p> </div> </div> | | | | | | | | | |
| <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> | | | | | | | | | |
| <p>19A. DATE OF OPERATION 2</p> | | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | | | <p>20A. AUTOPSY? (Yes or No)
YES</p> | | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> | | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | | | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | | | |
| <p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p> | | | <p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | | <p>21F. HOW DID INJURY OCCUR?</p> | | | |
| <p>22. I certify that (I) (this hospital) attended the deceased from 24 April 1966 to 24 April 1966, that (I) (we) last saw the deceased alive on 24 April 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</p> | | | | | | | | | |
| <p>23A. SIGNATURE
Joseph I. Berman</p> | | | | | <p>M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/></p> | | | <p>23B. DATE SIGNED
24 April 66</p> | |
| <p>23C. PHYSICIAN'S NAME (Type)
JOSEPH I. BERMAN</p> | | | | | <p>23D. ADDRESS BALTIMORE CITY HOSPITALS
 4940 Eastern Avenue, Baltimore, Md. 21224</p> | | | | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify)
Burial</p> | | | <p>24B. DATE
4-28-66</p> | | <p>24C. NAME OF CEMETERY or CREMATORY
Oak Lawn Cemetery</p> | | <p>24D. LOCATION (City, town, or county) (State)
7225 Eastern Blvd. Ba. Co., Md.</p> | | |
| <p>25A. DATE REC'D BY HEALTH DEPT.
APR 28 1966</p> | | | <p>25B. NAME OF REGISTRAR
Robert E. Taylor</p> | | | <p>25C. FUNERAL DIRECTOR ADDRESS
Charles S. Feiler
 901 S. Conkling St. Balto., Md.</p> | | | |

(19) I

K-1601

66 04345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66 04345

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Kieffer, Ethel Marie

2. DATE AND HOUR OF DEATH

4/24/66

10:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

North Charles General Hosp.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

BALTIMORE

C. CITY OR TOWN, (If outside city limits, write RURAL and give township)

Baltimore

2224 BOWLEY'S
QUARTERS

D. STREET ADDRESS (If rural, give location)

New Section Road Box 624 5370

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

12/30/02

9. AGE (In years
last birthday)

63 yrs.

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

retired.

10B. KIND OF BUSINESS OR INDUSTRY

U.S. POST OFFICE

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

THOMAS BREMONT

14. MOTHER'S MAIDEN NAME

MINNIE YOUNG

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

218-10-6729

17. INFORMANT

STANLEY M. KIEFFER

ADDRESS

SAME.

18.

153.21

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) metastatic Carcinoma of Stomach.
(B) Stem Clary Curious Curious.
(C) Curious Curious Curious DiseaseINTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

7/8/65

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

Carinoma descending aorta

20A. AUTOPSY? (Yes or No)

—

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY

(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/12/66 at 1:30 P.M. 1966. to 4/24/66 10:30 P.M. 1966. that (I) (we) lost saw the deceased olive on 4/24/66 at 10:30 P.M. 1966. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Stanley M. Kieffer

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

4/24/66

23C. PHYSICIAN'S
NAME (Type)

Samuel Handman

23D. ADDRESS

M.D.

1010 St Paul St - Balto. - Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

4-28-66

24C. NAME OF CEMETERY or CREMATORY

OAK LAWN CEM.

24D. LOCATION

(City, town, or county)

(State)

7225 EASTERN BLVD. BALTO. CO., MD.

25A. DATE REC'D BY HEALTH DEPT.

APR 28 1966

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

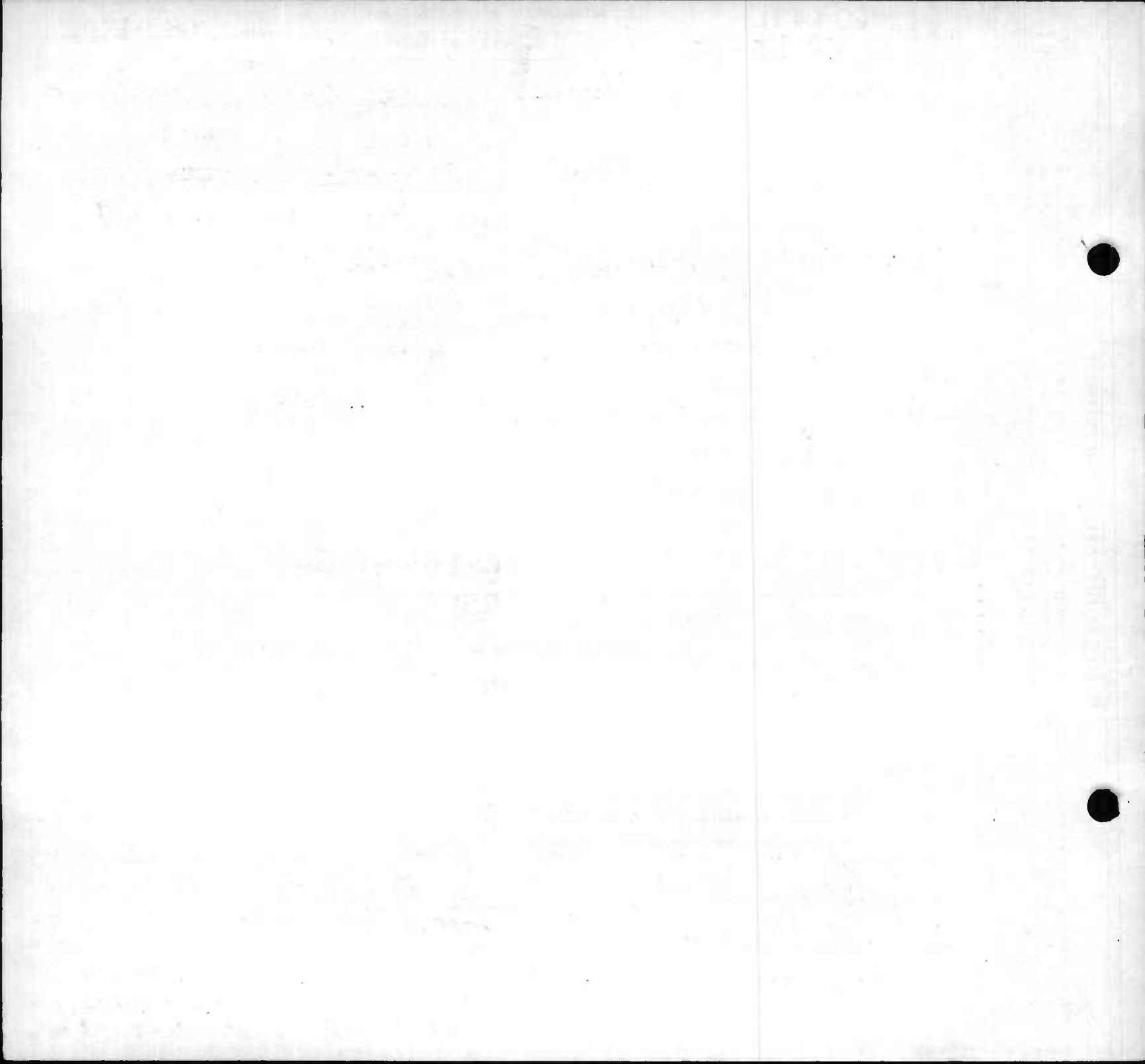
Charles L. Zeiler

ADDRESS

6224 EASTERN AVE.
BALTO., MD.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 04346 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04346 | |
|--|-------------------------|--|--|---|--|---|---|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Estella Brathuhn | | | | 2. DATE AND HOUR OF DEATH
4/26/66 4:45 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
3726 Old York Rd. | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY 9-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
3726 Old York Rd. | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
2/29/84 | 9. AGE (In years last birthday)
82 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
William Clubb | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth Retue | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-053228 | | 17. INFORMANT ADDRESS
Grover C. Brathuhn-3726 Old York Rd. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
PULMONARY EDEMA
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO
ARTERIOSCLEROTIC HEART DISEASE
(B) DUE TO
(C) | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | DIABETES MELLITUS | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/2/53 19 to 2/21 19 66 , that (I) (we) last saw the deceased alive on 2/21/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Robert E. May | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/26/66 | |
| 23C. PHYSICIAN'S NAME (Type)
Robert E. May | | | | 23D. ADDRESS
M.D. 5662 The Alameda | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/29/66 | | 24C. NAME OF CEMETERY or CREMATORY
Parkview Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1966 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
Robert C. Altenburg-6009 Harford Rd. Funeral Home, Inc. | | | |

PULMONARY EDEMA

ASTHMA
HEART DISEASE

DIABETES (MELLITUS)

2/21

2/21/23

4/22/22

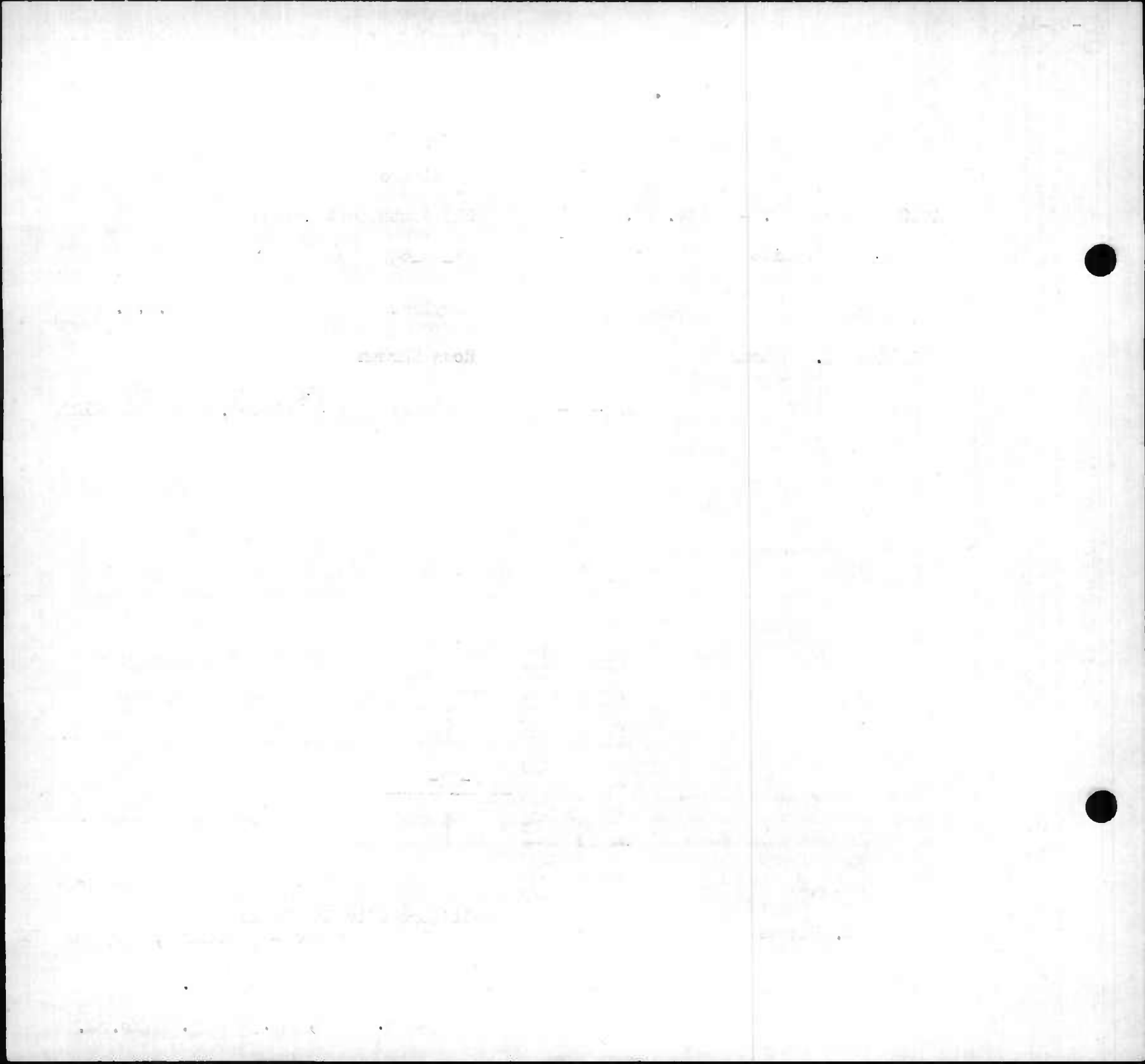
X

Robert S. Thayer

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

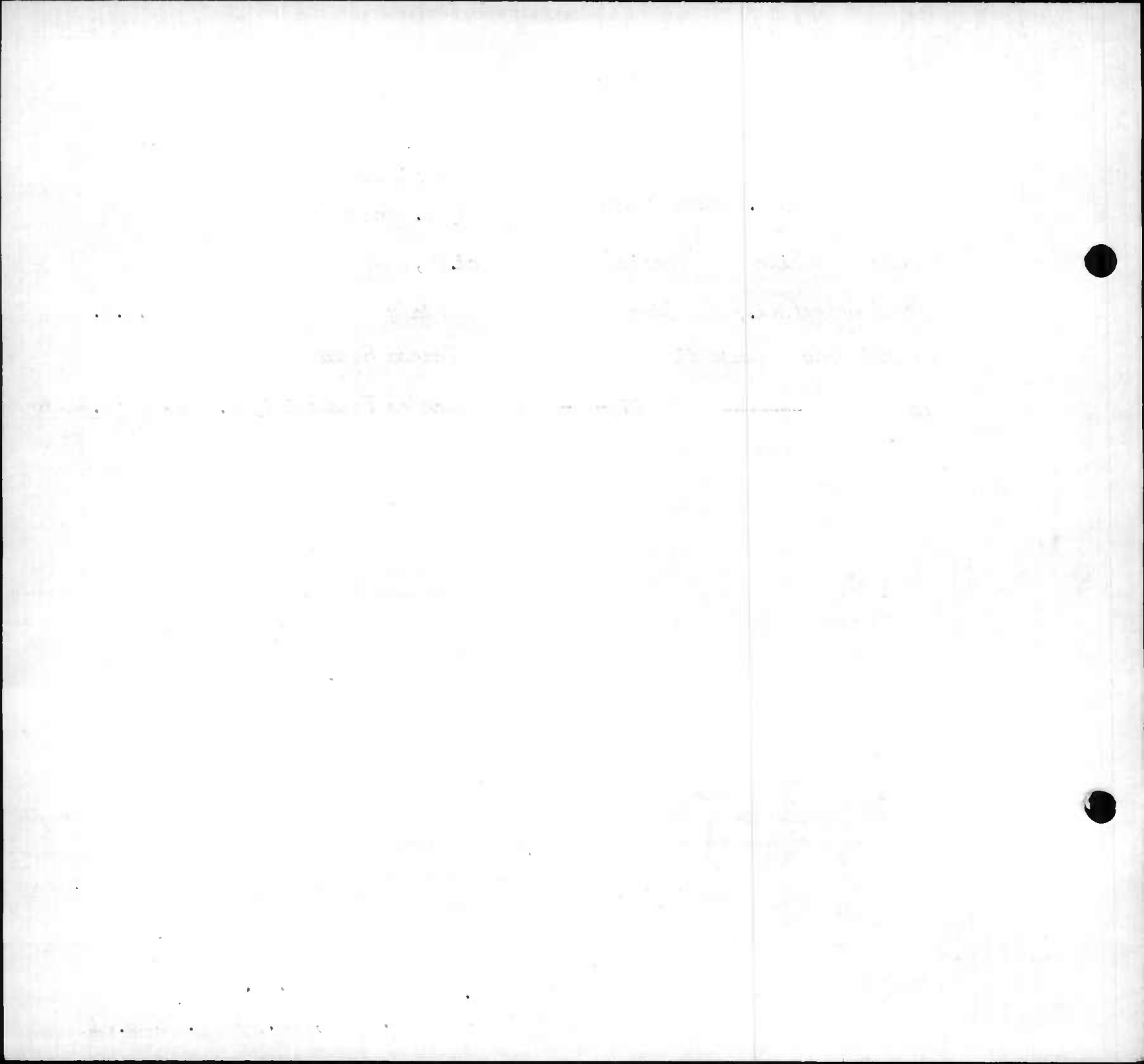
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04347 | |
|---|-------------------------|---|-------------------------------------|---|---|
| BIRTH NO. 66 04347 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) GEORGE H. THOMS | | | | 4/26/66 11 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
BALT. CITY HOSPITAL
4940 Eastern Ave. - Balto. Md. 21224 | | | | A. STATE Maryland
B. COUNTY 26-10 | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| | | | | O. STREET ADDRESS (If rural, give location)
213 South East Avenue | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
11-26-95 | 9. AGE (In years last birthday)
70 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Guard | | 10B. KIND OF BUSINESS OR INDUSTRY
Industry | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
William L. Thoms | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes | | | | 14. MOTHER'S MAIDEN NAME
Rosa Ehrman | |
| 16. SOCIAL SECURITY NO.
212-10-1071 | | 17. INFORMANT ADDRESS
4940 Eastern Avenue
RECORDS: BCH: Baltimore, Maryland 21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
163X I
Carcinoma of Lung | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (he) (this hospital) attended the deceased from Feb 26 19 66 to April 26 19 66 , that (he) (we) last saw the deceased alive on 4-26 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
B. Hughes | | | | 23B. DATE SIGNED
4-26-66 | |
| 23C. PHYSICIAN'S NAME (Type)
B. Hughes | | | | 23D. ADDRESS
Baltimore City Hospitals
4940 Eastern Avenue - Baltimore, Maryland #24 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/30/66 | | 24C. NAME OF CEMETERY or CREMATORY
Oak Lawn Cemetery | |
| 24D. LOCATION (City, town, or county)
Baltimore Md. | | 24E. NAME OF REGISTRAR
APR 28 1966 | | 24F. FUNERAL DIRECTOR ADDRESS
John A. Moran, Inc. 3000 E. Balto. St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04348 | |
|--|-----------|--|--|--|--|
| BIRTH NO. 66 04348 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Alberto Trasarti | | April 27 / 66 10 ¹⁵ A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | A. STATE
B. COUNTY | | |
| 13 N. Decker Avenue | | | Maryland
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location)
13 N. Decker Avenue | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| Male | White | Married | Oct. 28, 1886 | 79 | Steelworker (Ret.) |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Steelworker (Ret.) | | | Italy | | U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Ferdinando Trasarti | | | Teresa Braca | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| no | | 213-09-2932 | Mercedes Trasarti 13 N. Decker Ave. Balto | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| 332 XI | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES | | | (A) Cerebral Vascular Thrombosis 1 week | | |
| | | | (B) Athero-Sclerotic Vascular Disease Unknown | | |
| | | | (C) | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from February 13 1966 to April 27 1966, that (I) (we) lost saw the deceased alive on April 26 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Philibert Artigiani M.D. | | | | April 27/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| Philibert Artigiani M.D. | | | 2305 Mayfield Ave. Balto 13, Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | 4/30/66 | Holy Redeemer Cem. | | Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| APR 28 1966 | | R. E. Fable, M.D. | | John A. Moran, Inc. 3000 E. Balto. St | |



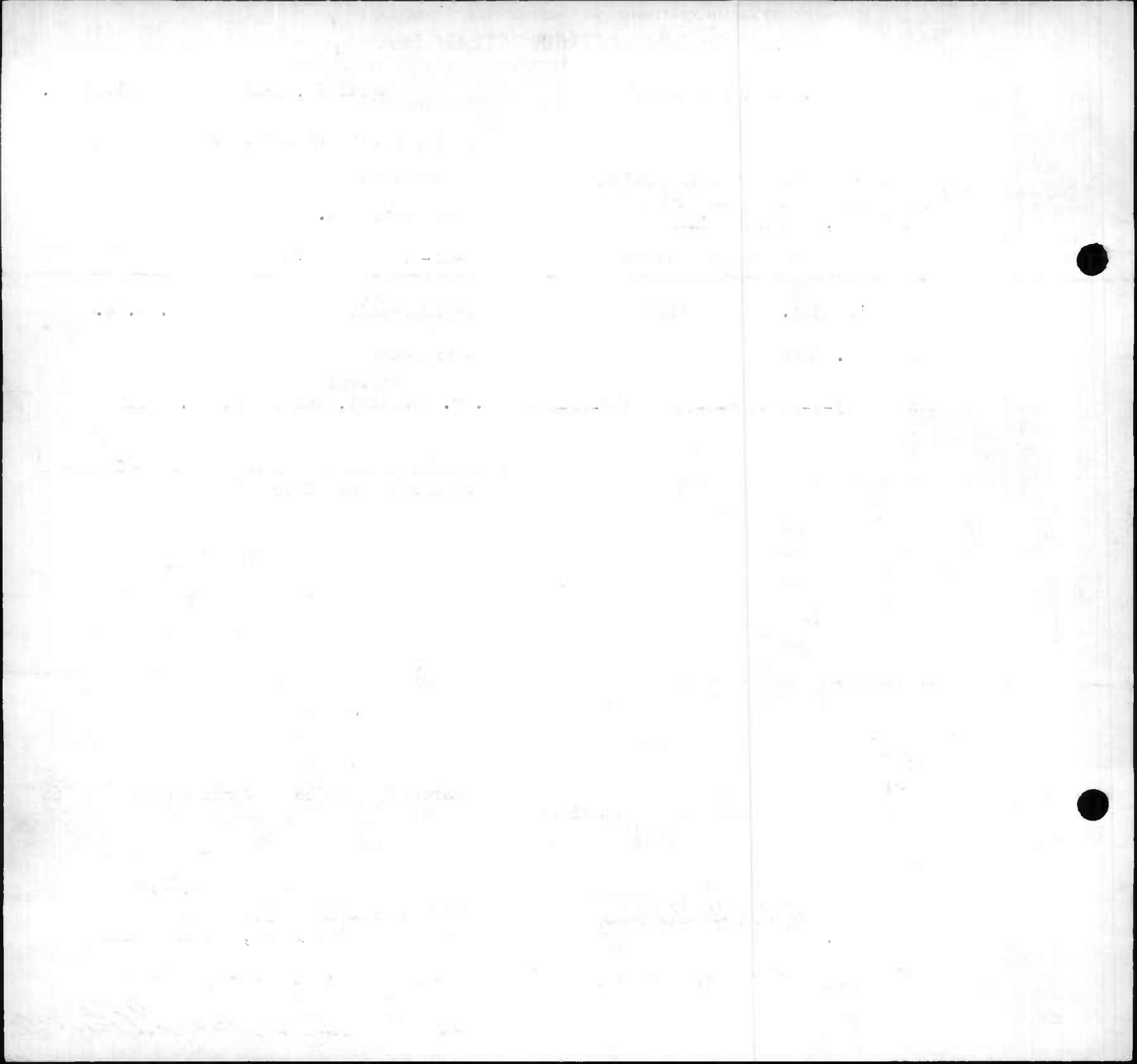
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 04349 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 04349 | |
|---|-----------------------------|---|---|--|---|--|---|-------------------------|--|
| 1. NAME OF DECEASED
(Type or Print) BABB, WILLIAM LEONARD | | | | 2. DATE AND HOUR OF DEATH
April 26, 1966 11:15 P. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pennsylvania B. COUNTY Philadelphia
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Philadelphia
D. STREET ADDRESS (If rural, give location)
6042 Edmund St. | | | | | |
| 5. SEX
Male | 6. RACE
Caucasian | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
6-11-91 | 9. AGE (In years last birthday)
74 | If Under 1 Yr. Months: Days: Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Plumber's Asst. | | | 10B. KIND OF BUSINESS OR INDUSTRY
Unknown | | 11. BIRTHPLACE (State or foreign country)
Philadelphia Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | |
| 13. FATHER'S NAME
William F. Babb | | | | 14. MOTHER'S MAIDEN NAME
Anna Beebe | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 3-8-18 to 6-2-19 | | | 16. SOCIAL SECURITY NO.
181-22-0874 | | 17. INFORMANT Records ADDRESS
V. A. Hospital, Baltimore, Md. 21218 | | | | |
| 18. 162.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Bronchogenic Carcinoma with Metastasis to the Liver | | | | CAUSE OF DEATH
(A) Bronchogenic Carcinoma with Metastasis to the Liver
(B)
(C)
INTERVAL BETWEEN ONSET AND DEATH
1 to 2 months | | | | | |
| II
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from March 25 19 66 to April 26 19 66 , that X (we) last saw the deceased alive on April 26 19 66 and that in X (our) opinion death occurred on the date and hour and from the causes stated above. X (We) (did) XXXX view the body after death. | | | | | | | | | |
| 23A. SIGNATURE

Ralph H. Twining | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/27/66 | | | |
| 23C. PHYSICIAN'S NAME (Type)
RALPH H. TWINING | | 23D. ADDRESS VA HOSPITAL 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5/2/66 | | 24C. NAME OF CEMETERY or CREMATORY
BEVERLY NATIONAL | | 24D. LOCATION (City, town, or county) (State)
BEVERLY, N.C. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | 25B. NAME OF REGISTRAR
Robert E. Farkley, M.D. | | 25C. FUNERAL DIRECTOR
John E. Farkley | | ADDRESS
5521 Loch Raven | | | |

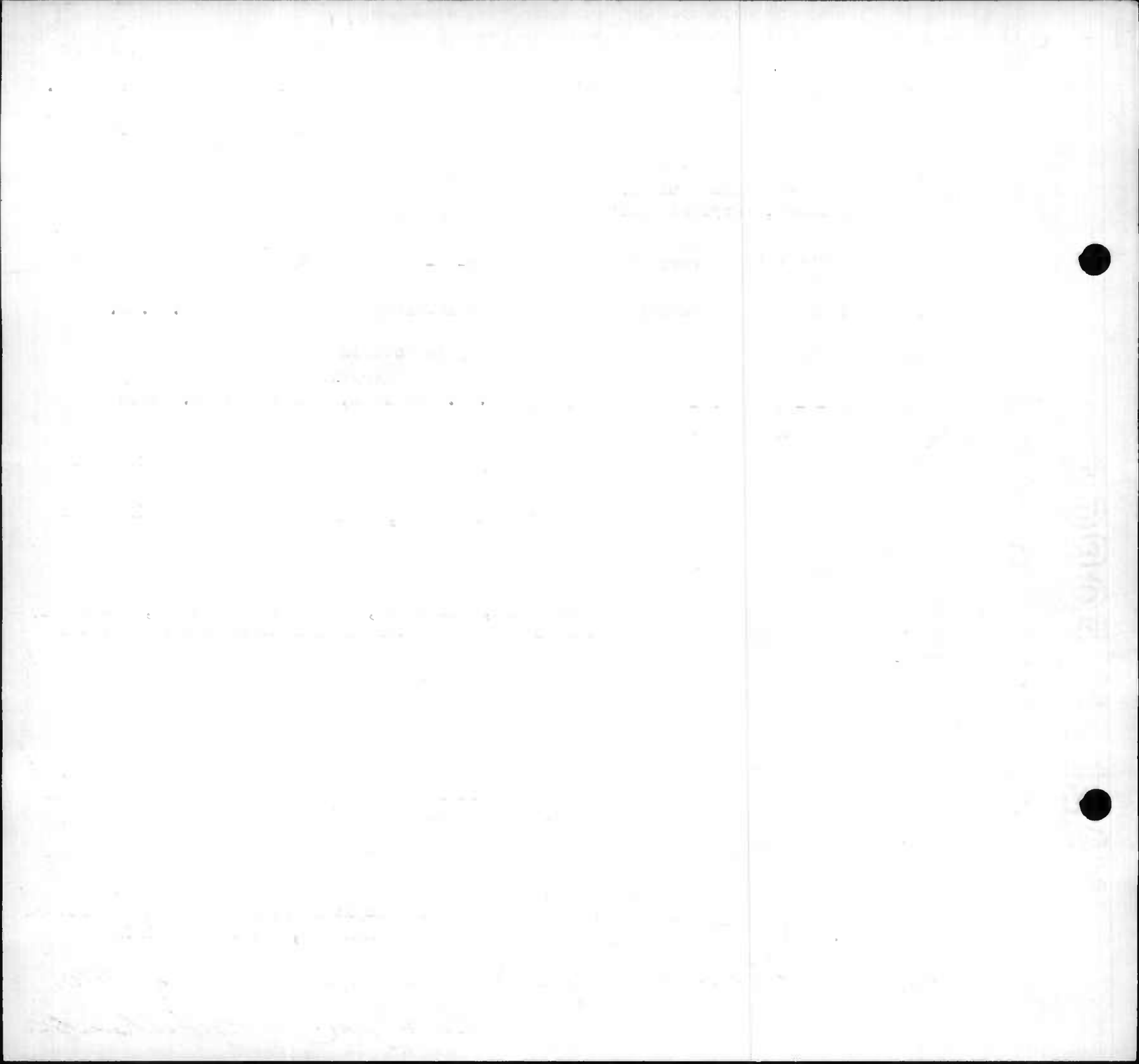


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 04350 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 04350 | |
|--|-----------------------------|---|--|---|--|---|-----------------------------|---|--|
| 1. NAME OF DECEASED
(Type or Print) LOWTHER, William Robert | | | | 2. DATE AND HOUR OF DEATH
April 26, 1966 11:10 P. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pennsylvania B. COUNTY Philadelphia
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Philadelphia
D. STREET ADDRESS (If rural, give location)
1202 Arch Street | | | | | |
| 5. SEX
Male | 6. RACE
Caucasian | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
1-19-84 | 9. AGE (In years last birthday)
82 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Horse Walker | | | 10B. KIND OF BUSINESS OR INDUSTRY
Racing | | 11. BIRTHPLACE (State or foreign country)
Delaware | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Moses Lowther | | | | 14. MOTHER'S MAIDEN NAME
Lydia Roberts | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 10-9-13 to 6-9-20 | | | | 16. SOCIAL SECURITY NO.
174-01-1466 | | 17. INFORMANT Records ADDRESS
V. A. Hospital, Baltimore, Md. 21218 | | | |
| 18. 460X 9-002.1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Pulmonary Emboli
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Varicose Veins, Legs | | | | CAUSE OF DEATH
(A) Pulmonary Emboli
DUE TO
(B) Varicose Veins, Legs
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
2 hours
2 months | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Tuberculosis, Pulmonary, Moderately Advanced, Active 3/66
Anemia, secondary to Chronic Infection and Malnutrition | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 13 19 66 to April 26 19 66 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on April 26 19 66 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (XXXX) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE

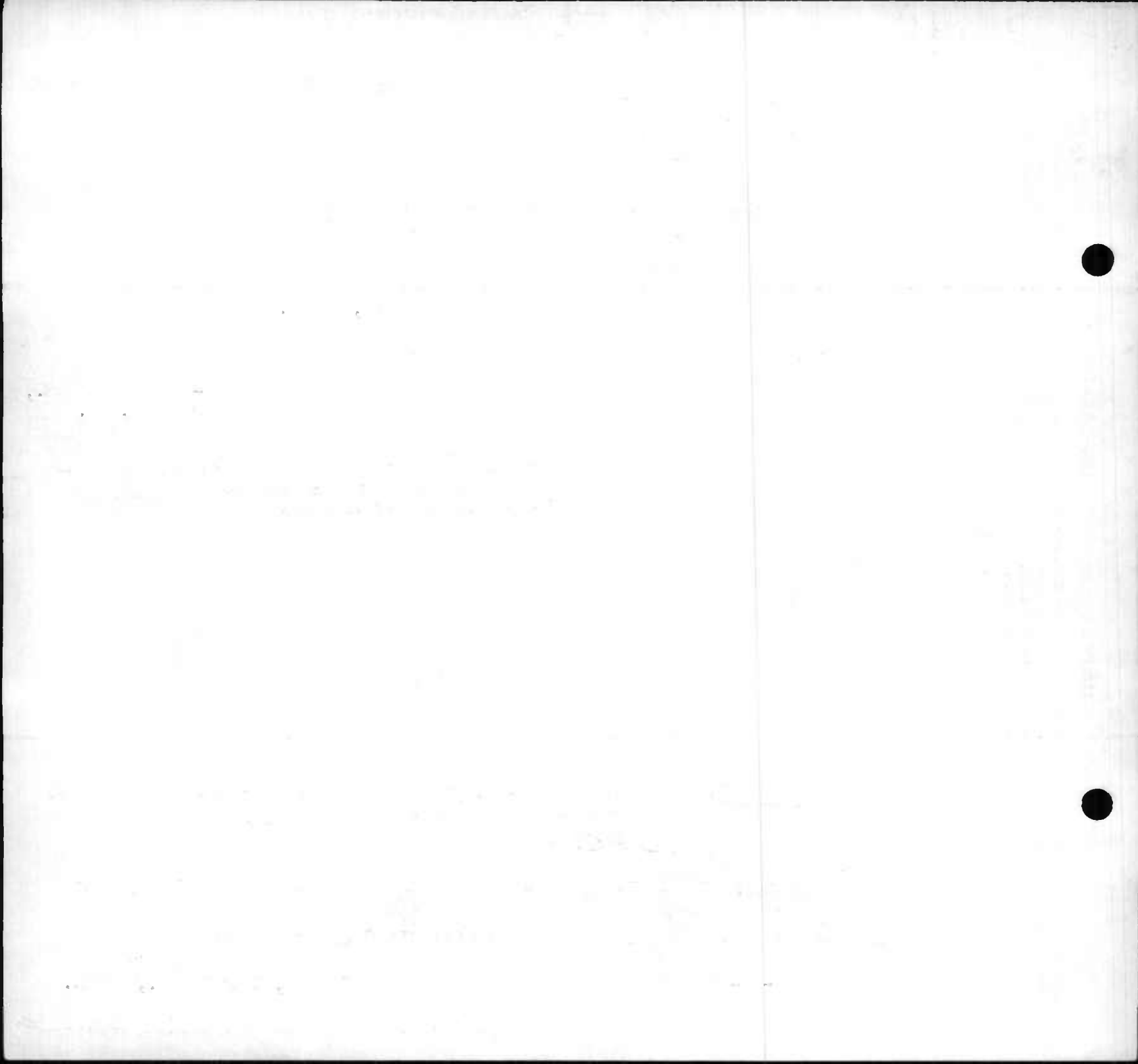
YOUNG E. CHUN | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | | | |
| 23C. PHYSICIAN'S NAME (Type)
YOUNG E. CHUN | | | | 23D. ADDRESS
VA Hospital 3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/29/66 | | 24C. NAME OF CEMETERY or CREMATORY
BALTIMORE NATIONAL | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE Co., MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | 25B. NAME OF REGISTRAR
R. E. Fawcett | | 25C. FUNERAL DIRECTOR
John E. Johnson | | ADDRESS
852 Loch Raven Blvd. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 04351 | |
|---|-------------------------|---|------------------------------------|---|--|---|--|
| BIRTH NO. 66 04351 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Fritz, George | | 2. DATE AND HOUR OF DEATH
April 26/1966 7:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
The Johns Hopkins Hospital | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Perry Hall 53-00 | | | |
| D. STREET ADDRESS (If rural, give location)
329 Silver Spring Road | | | | | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
4-11-07 | 9. AGE (In years last birthday)
59 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Smithmill, Penna. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Demco Fritz | | | | 14. MOTHER'S MAIDEN NAME
Anna | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS
329 Silver Spring Rd Perry Hall, Md. | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Acute Myocardial Infarction
Hypertensive arteriosclerotic Cardiovascular Disease | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
11 hours | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | | |
| | | | | (B) DUE TO | | | |
| | | | | (C) | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from 4/25 19 66 to 4/26 19 66 , that (I) <u>we</u> last saw the deceased alive on 4/26 19 66 and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If <u>we</u> did (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
E. Eugene Page | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/26/66 | |
| 23C. PHYSICIAN'S NAME (Type)
E. Eugene Page | | | | 23D. ADDRESS
Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-29-66 | | 24C. NAME OF CEMETERY or CREMATORY
Pleasant Hill Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore Co., Penna. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | | | 25B. NAME OF REGISTRAR
E. Eugene Page | | 25C. FUNERAL DIRECTOR
William E. Schuman | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04352 | |
|---|--|---|--|--|--|
| BIRTH NO.
66 04352 | | M.E. CASE NO. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print)
Bessie F. Stinefelt | | | 2. DATE AND HOUR OF DEATH
April 26, 1966 7:15 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
Ardleigh Nursing Home
2095 Rockrose Avenue | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 1308
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1323 Union Avenue | | |
| 5. SEX
Female | | 6. RACE
white | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widow | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Spinner | | 10B. KIND OF BUSINESS OR INDUSTRY
Textile Mill | | 8. DATE OF BIRTH
Nov. 20, 1892 | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 9. AGE (In years last birthday)
73 | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Robert Griffith | | | 14. MOTHER'S MAIDEN NAME
Annie Gill | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-18-4345 | | 17. INFORMANT
Robert L. Stinefelt ADDRESS
1005 Kingston Road | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
Parkinson's disease
(A) DUE TO
Arteriosclerotic cardio-vascular disease
(B) DUE TO
Cerebral vascular changes
(C) DUE TO
INTERVAL BETWEEN ONSET AND DEATH
6 yrs.
10 yrs.
6 mo. | | | | | |
| MEDICAL CERTIFICATION | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
II | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from February 16, 1966 to April 26, 1966 , that (I) (we) last saw the deceased alive on April 25, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Lloyd E. Saylor M.D. | | | | 23B. DATE SIGNED
4/28/66 | |
| 23C. PHYSICIAN'S NAME (Type)
Lloyd Saylor M.D. | | | | 23D. ADDRESS
3902 Greenmount Avenue, Balto., Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
29 Apr. 66 | | 24C. NAME of CEMETERY or CREMATORY
Meadowridge Memorial Park | |
| 24D. LOCATION
Howard County, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Burges Funeral Home, 3631 Falls Road | | | |

Burt Co. N. Rylander - 11/20/52 - A43991

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | |
|--|--|---------------|--|---|---|----------------------------|--|------------------------------------|--|--|--|--------------------------|--|----------------------------------|--|
| BIRTH NO. 66 04353 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 04353 | | | | | |
| M.E. CASE NO. | | | | | 1. NAME OF DECEASED (Type or Print) OLIVER R CHRISTOPHER | | | | | 2. DATE AND HOUR OF DEATH APRIL 27, 1966 1:05 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 12-77 | | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
49 NORTH CHARLES GENERAL HOSP. | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 11 | | | | | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
2842 HUNTINGDON AVENUE | | | | | | | | | | |
| 5. SEX MALE | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE | | 8. DATE OF BIRTH 4/14/1891 | | 9. AGE (In years last birthday) 75 | | If Under 1 Yr. Months: Days: Hours: Min. | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) UNKNOWN | | | | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | 13. FATHER'S NAME UNKNOWN | | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | | 16. SOCIAL SECURITY NO. 215-34-5842 | | | | | 17. INFORMANT JOHN MORRISON ADDRESS 2742 HUNTINGDON AVE. | | | | | |
| 18. 337X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | CAUSE OF DEATH SUBDURAL HEMORRHAGE | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | (A) DUE TO | | | | | |
| | | | | | | | | | | (B) DUE TO | | | | | |
| | | | | | | | | | | (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) No | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that N (this hospital) attended the deceased from APRIL 2nd 1966 to APRIL 27 1966, that N (we) last saw the deceased alive on APRIL 27 1966 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. N (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 23A. SIGNATURE Luis M. Tomas | | | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 4-27-66 | | | |
| 23C. PHYSICIAN'S NAME (Type) LUIS ELIAS | | | | | | | | | | 23D. ADDRESS M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE 30 Apr. 66 | | | | | 24C. NAME OF CEMETERY OR CREMATORY Mays Chapel Cemetery | | | | | |
| | | | | | | | | | | 24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 29 1966 | | | | | 25B. NAME OF REGISTRAR Robert E. Feltman | | | | | 25C. FUNERAL DIRECTOR Burgee Funeral Home 3631 Falls Road | | | | | |
| 25D. ADDRESS Horace F. Burgee | | | | | | | | | | | | | | | |

When change from Committee
see letter in file - (see if the
information is ready)

MALE WHITE SINGLE

NORTH CHARLES GENERAL MORG

3843 HUNTINGTON AVENUE
BALTIMORE 11

4/14/1941 12

D. S. A.

JOHN W. MORGAN, JR.
3843 HUNTINGTON AVENUE

SUBSTANTIAL BACKGROUND

LUIS ELIAS

WILLIAM W. TOW

APRIL 25

APRIL 24 10

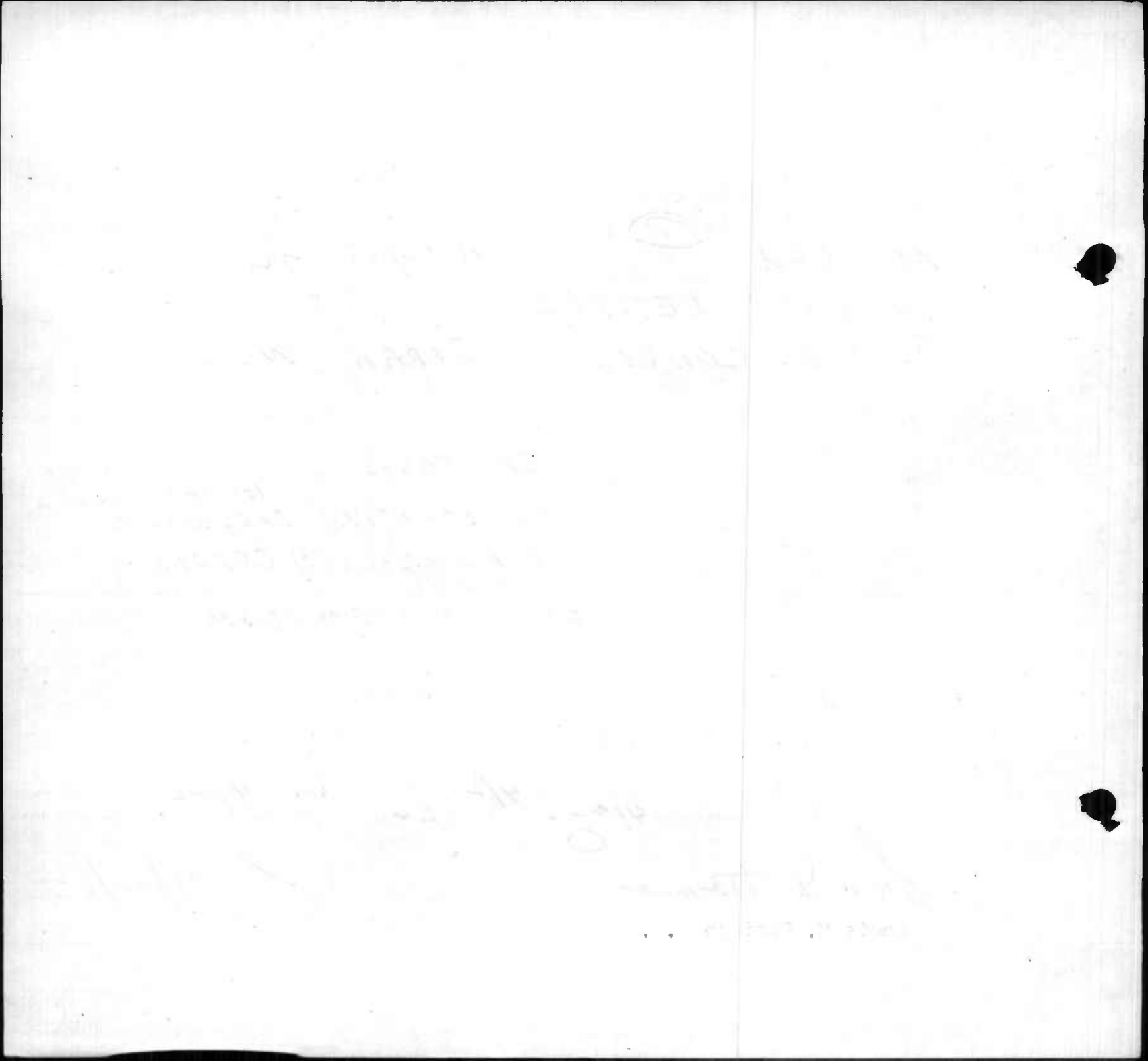
APRIL 24

4-25-41

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|---|----------------|--|--|---|---------------------------------------|--|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| Registered No. 66 04354 | | | | | | | | | | | |
| BIRTH NO.
66 04354 | | M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print)
HARVEY CONDON | | | | | | 2. DATE AND HOUR OF DEATH
4/22/66 2:55 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY Howard | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
St. Ann's Hospital | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
JESSUP 6300 | | | | | |
| O. STREET ADDRESS (If rural, give location)
Mossman Road | | | | | | | | | | | |
| 5. SEX
M | 6. RACE
CAU | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH
10/2/89 | 9. AGE (In years last birthday)
76 | If Under 1 Yr. Months: Ooys | | If Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
WEAVER | | | | 10B. KIND OF BUSINESS OR INDUSTRY
RETIRED | | | | 11. BIRTHPLACE (State or foreign country)
Md | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
JOHN E. CONDON | | | | | | 14. MOTHER'S MAIDEN NAME
SARAH WEST | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Annie Condon | | | | | |
| 18. 443X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
TESTIC. HYPAGONADISM | | | | | | CAUSE OF DEATH
(A) EPISTAXIS
DUE TO
(B) HYPERTENSIVE CARDIOVASC.
DUE TO
(C) ACROMEGALY D) CEREBRAL THROMBOSIS
2° ASCVD | | | | INTERVAL BETWEEN ONSET AND DEATH
10-12 hrs
HEART DIS. | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/21 1966 to 4/22 1966, that (I) (we) last saw the deceased alive on 4/22 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Louis M. Damiano | | | | | | M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/22/66 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Louis M. Damiano M.D. | | | | | | 23D. ADDRESS
M.O. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-25-66 | | 24C. NAME OF CEMETERY or CREMATORY
Savage Cem. | | | | 24D. LOCATION (City, town, or county)
Savage Md. | | I State | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | | | 25B. NAME OF REGISTRAR
P. E. Fairbank | | | | 25C. FUNERAL DIRECTOR
William J. Damiano | | | |
| | | | | | | | | ADDRESS
Savage Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

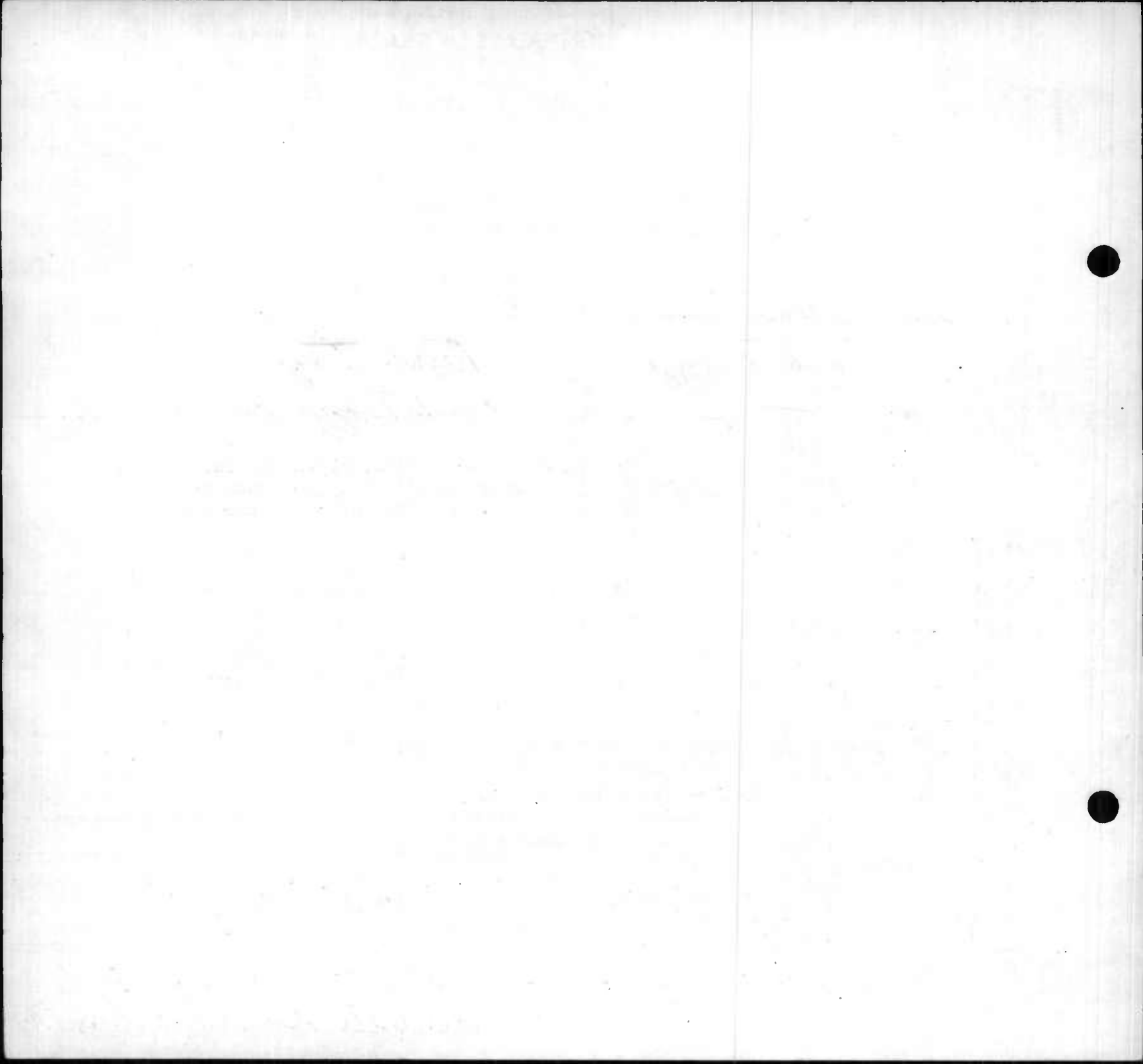
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | | | | | | |
|--|---------------------|--|--|---|--|---|--|---|--|
| BIRTH NO.
66 04355 | | Registered No. 66 04355 | | | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) FRANK TUOZZO | | | | 2. DATE AND HOUR OF DEATH
APRIL 20 1966 7:45 PM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
FRANKLIN SQUARE HOSP. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY HOWARD
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
LAUREL
D. STREET ADDRESS (If rural, give location)
GROSS AVE | | | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
M | | 8. DATE OF BIRTH
JUNE 22 1897 | 9. AGE (In years last birthday)
68 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
restaurateur | | 10B. KIND OF BUSINESS OR INDUSTRY
own restaurant | | 11. BIRTHPLACE (State or foreign country)
NEW JERSEY | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
Frank Tuozzo | | | | 14. MOTHER'S MAIDEN NAME
Rachel Tazior | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | |
| 16. SOCIAL SECURITY NO.
no | | 17. INFORMANT
Frank Tuozzo, Laurel Md. | | | | ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

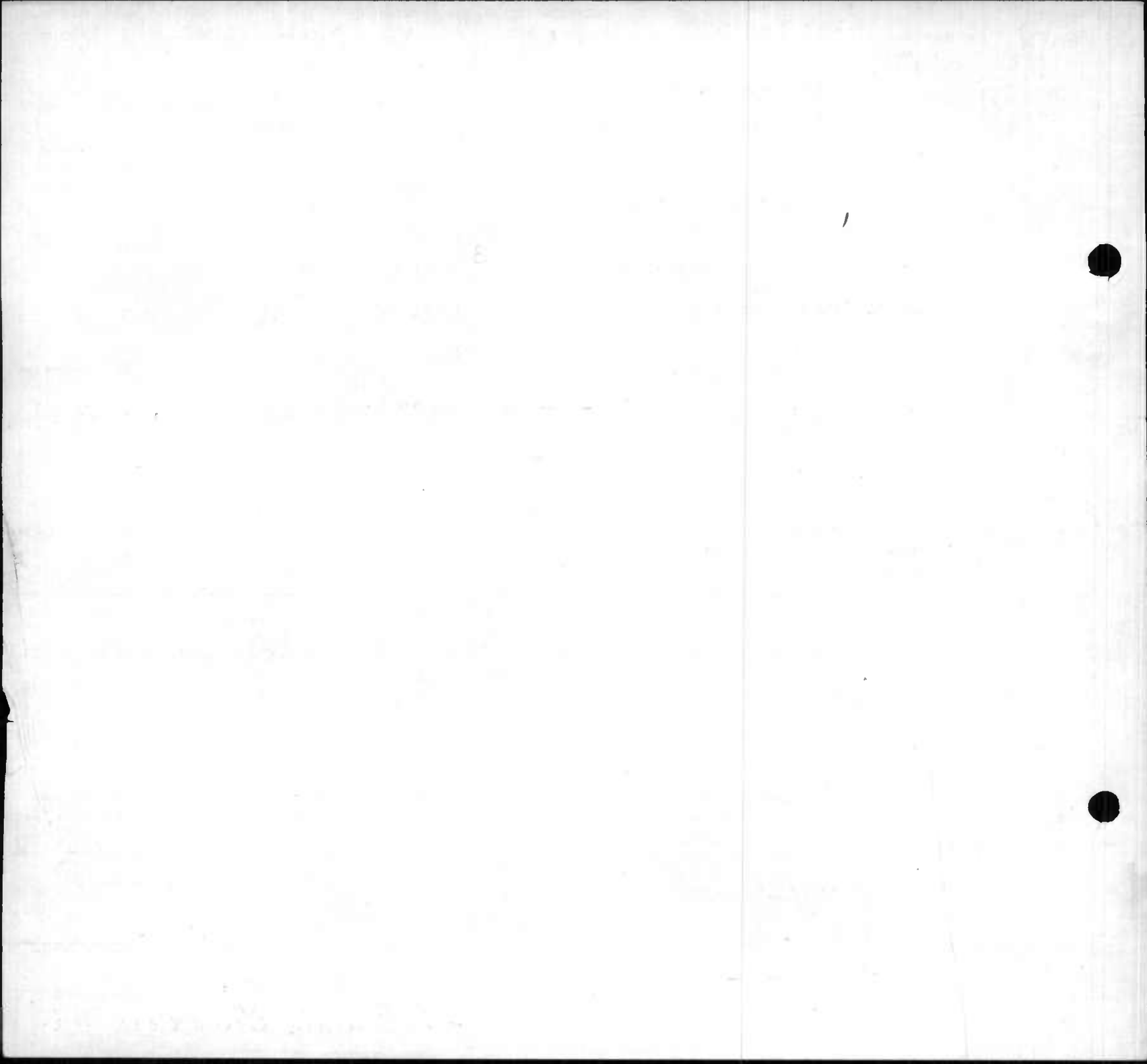
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
Pulmonary embolus, right, cardiac arrest complicating post resection of ruptured abdominal aneurysm | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | 19A. DATE OF OPERATION
4-20-66 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
RUPTURED ABDOMINAL ANEURYSM | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.)
<input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
no | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
<input type="checkbox"/> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 19 1966 to APRIL 20 1966 , that (I) (we) last saw the deceased alive on APRIL 20 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Wilfredo M. Mediano | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
APRIL 20, 1966 | | | |
| 23C. PHYSICIAN'S NAME (Type)
WILFREDO M. MEDIANO | | | | 23D. ADDRESS
FRANKLIN SQUARE HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-23-66 | | 24C. NAME OF CEMETERY or CREMATORY
St Marys Cemetery | | 24D. LOCATION (City, town, or county) (State)
Laurel Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1966 | | 25B. NAME OF REGISTRAR
R. E. FARRER | | 25C. FUNERAL DIRECTOR
Dr. W. H. Donaldson, Laurel Md. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|------------------------|--|---|---|--|--|--|-----------------------------|--|
| BIRTH NO. 66 04358 | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. 66 04358 | | | | |
| 1. NAME OF DECEASED
(Type or Print)
Robert Rampmeyer | | | | | 2. DATE AND HOUR OF DEATH
4/27/66 12 50 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
Johns Hopkins Hospital
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Caroline
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Ridgely
D. STREET ADDRESS (If rural, give location) None | | | | |
| 5. SEX
MALE | 6. RACE
CAUC | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
3/9/42 | | 9. AGE (In years last birthday)
24 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Compositer News Paper | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
Andrew Rampmeyer | | | | | 14. MOTHER'S MAIDEN NAME
Mildred Gross | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
219-36-5511 | | 17. INFORMANT ADDRESS
Nancy Rampmeyer Ridgely, Maryland | | | | |
| 18. 355-X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
INCREASED INTRACEREBRAL PRESSURE UNKNOWN CAUSE | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 month | | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/25 19 66 to 4/27 19 66 , that (I) (we) last saw the deceased alive on 4/27 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Leonard J. Quadracci | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/27/66 | | |
| 23C. PHYSICIAN'S NAME (Type)
Leonard J. Quadracci | | | | | 23D. ADDRESS
M.D. The Johns Hopkins Hospital | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-30-66 | | 24C. NAME of CEMETERY or CREMATORY
Greensboro | | 24D. LOCATION (City, town, or county) (State)
Greensboro, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | | 25B. NAME OF REGISTRAR
Robert E. J... | | 25C. FUNERAL DIRECTOR ADDRESS
J. E. Boulais Greensboro, Md. | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | Registered No. <u>68 04357</u> | |
|--|---------------------|---|-------------------------------------|---|---|
| BIRTH NO. <u>86 04357</u> | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Mollie Snyder</u> | | 2. DATE AND HOUR OF DEATH
<u>April 27 1966 9:10 P.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Maryland General Hospital</u> | | A. STATE <u>Maryland</u>
B. COUNTY <u>6-04</u> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>2014 E. Baltimore ST</u> | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>WIDOWED</u> | 8. DATE OF BIRTH
<u>5-1-1888</u> | 9. AGE (In years last birthday)
<u>77</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Lithuania</u> | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>216-32-5891</u> | | 17. INFORMANT <u>Louis Meyers</u>
<u>(Brother-in-law)</u> ADDRESS <u>same</u> | |
| 18. <u>332X I</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | (A) <u>Cerebral Thrombosis</u>
DUE TO | | <u>1 day</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B)
DUE TO | | | |
| | | (C)
DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>Mesenteric Thrombosis</u> | | <u>1 day</u> | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>(3)</u> (this hospital) attended the deceased from <u>Apr. 26</u> 19 <u>66</u> to <u>Apr. 27</u> 19 <u>66</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>April 27</u> 19 <u>66</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>W. Michael Gould</u> | | | | 23B. DATE SIGNED
<u>4/27/66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>W. Michael Gould</u> | | | | 23D. ADDRESS
<u>M.D.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>4/29/1966</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>ROSEDALE</u> | |
| 24D. LOCATION
<u>BALTO</u> | | (City, town, or county) (State)
<u>MD</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 29 1966</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Johnson</u> | | 25C. FUNERAL DIRECTOR
<u>SYLVAN S. LEWIS + Son</u> ADDRESS <u>3319 OLYMPIA AVE</u> | |

General Hospital

F W

Thompson

Join E. 12-1

8

Thompson

(Bulldog) (Bulldog)

Carroll Thompson

Messing Thompson

1

Michael Ball

April 22 22

Apr 22

x

4/24/22

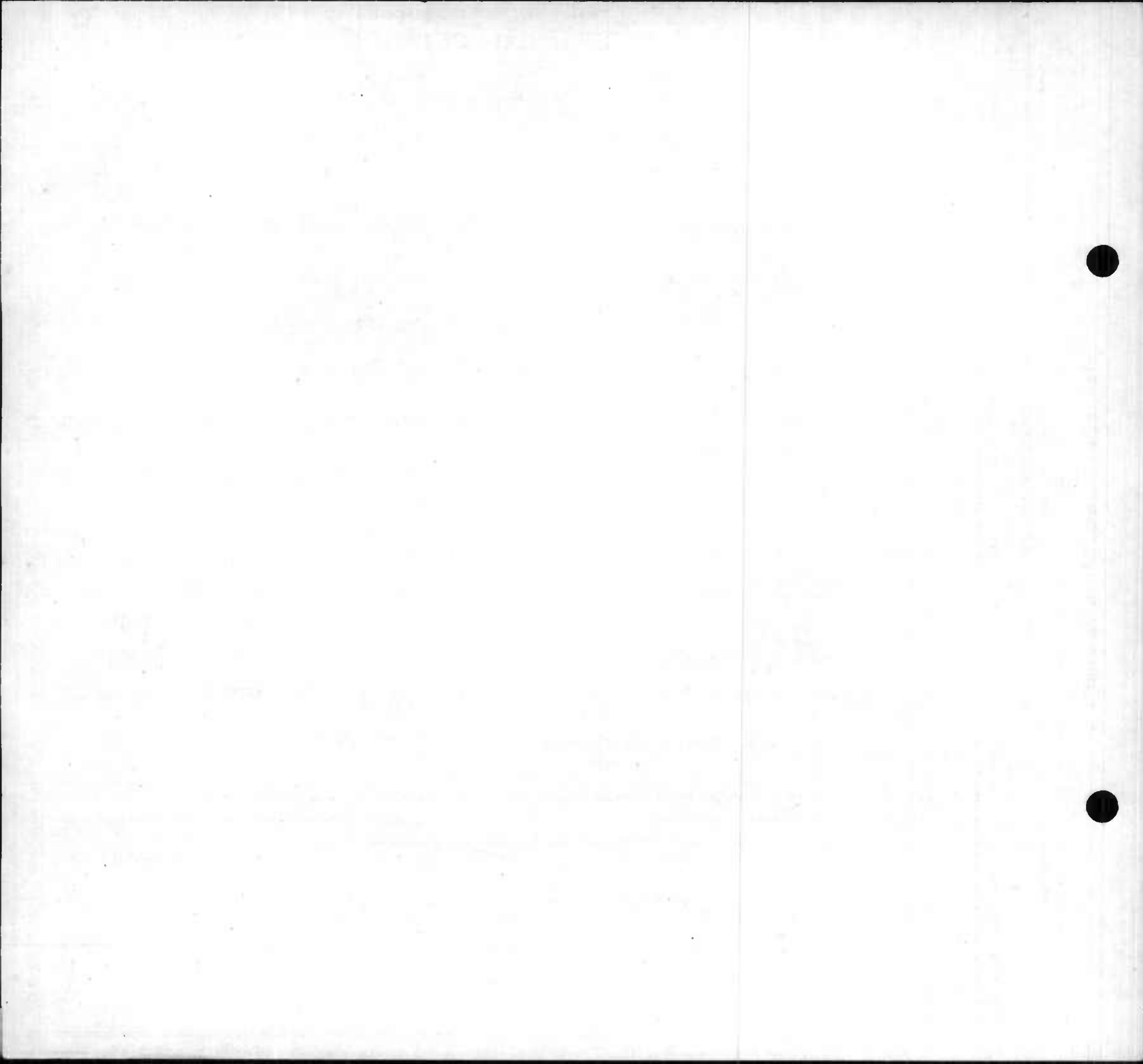
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. |
|--|---------------------------------|---|---|---|
| BIRTH NO. <u>66-08649</u> | | 66 04358 CERTIFICATE OF DEATH | | <u>66 04358</u> |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH <u>4/19/66 9 PM</u> | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Baby Girl Jackson</u> | | P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
<u>Mercy Hospital</u> | | A. STATE <u>Maryland</u> | | |
| | | B. COUNTY <u>9-09</u> | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>1337 E. North Avenue</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>N</u> | 7. MARRIED, (NEVER MARRIED) <u>WIDOWED, DIVORCED</u> (Specify) | 8. DATE OF BIRTH
<u>4-19-66</u> | 9. AGE (In years last birthday)
<u>6</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Baby</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
— | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>James Jackson</u> | | 14. MOTHER'S MAIDEN NAME
<u>Patricia Thompson</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
— | 17. INFORMANT ADDRESS | |
| 18. <u>773.5 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

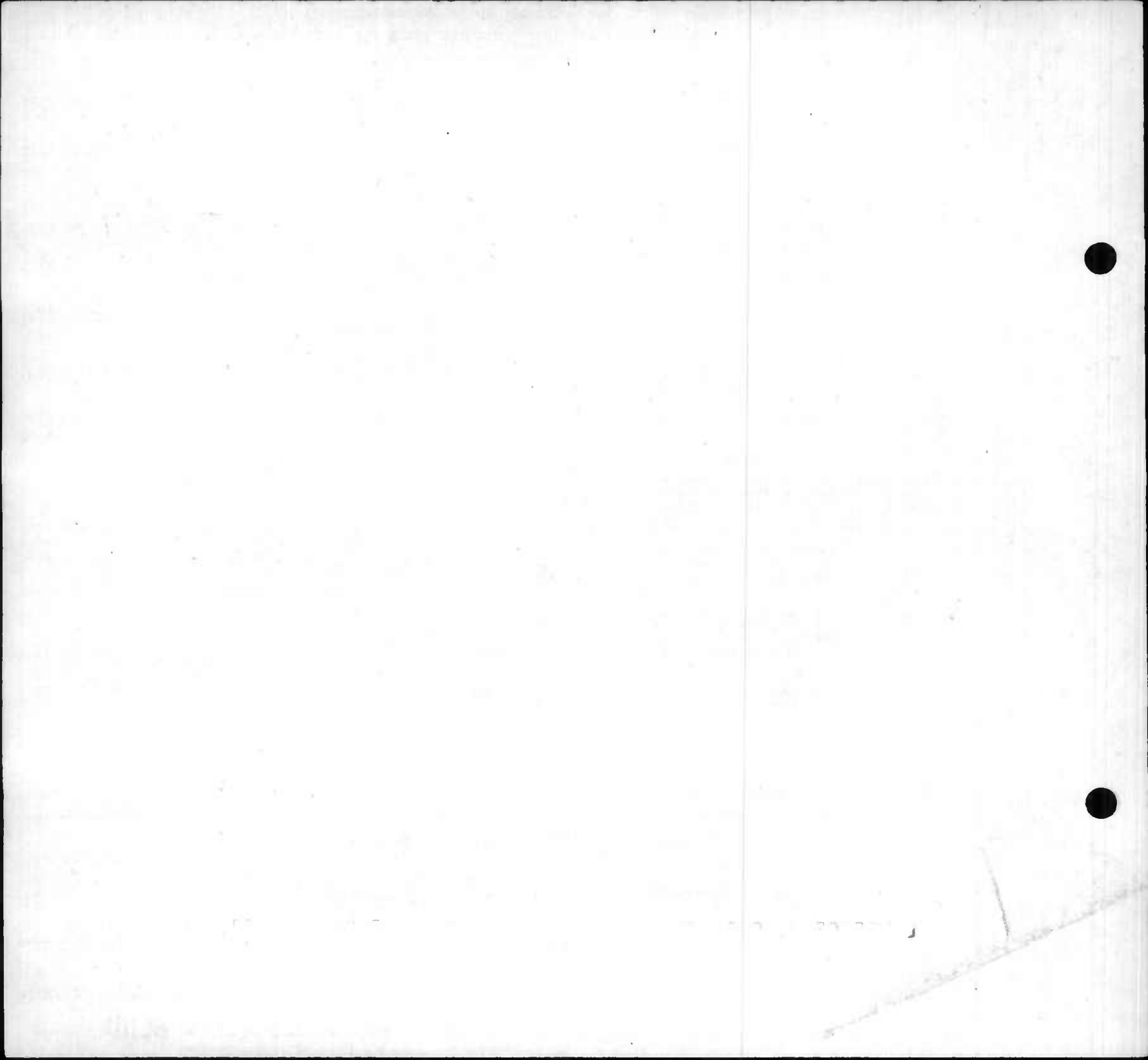
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <u>Rematurity; Resp. Distress</u>
DUE TO
(B) <u>Syndrome</u>
DUE TO
(C) — | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 hrs.</u> |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>None</u> | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
— |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
— | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
— | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?
— | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>4-19</u> 19 <u>66</u> to <u>4-19</u> 19 <u>66</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>4-19</u> 19 <u>66</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>Perry S. Shelton</u> | | | 23B. DATE SIGNED
<u>4-19-66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Perry S. Shelton</u> | | | 23D. ADDRESS
<u>Mercy Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>REMOVAL</u> | 24B. DATE
<u>APR 29 1966</u> | 24C. NAME OF CEMETERY or CREMATORY
<u>UNIVERSITY MEDICAL SCHOOL</u> | 24D. LOCATION (City, town, or county) (State)
<u>MARYLAND</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 29 1966</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Smith</u> | 25C. FUNERAL DIRECTOR ADDRESS
<u>MORTUARY SERVICE - BCHD</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

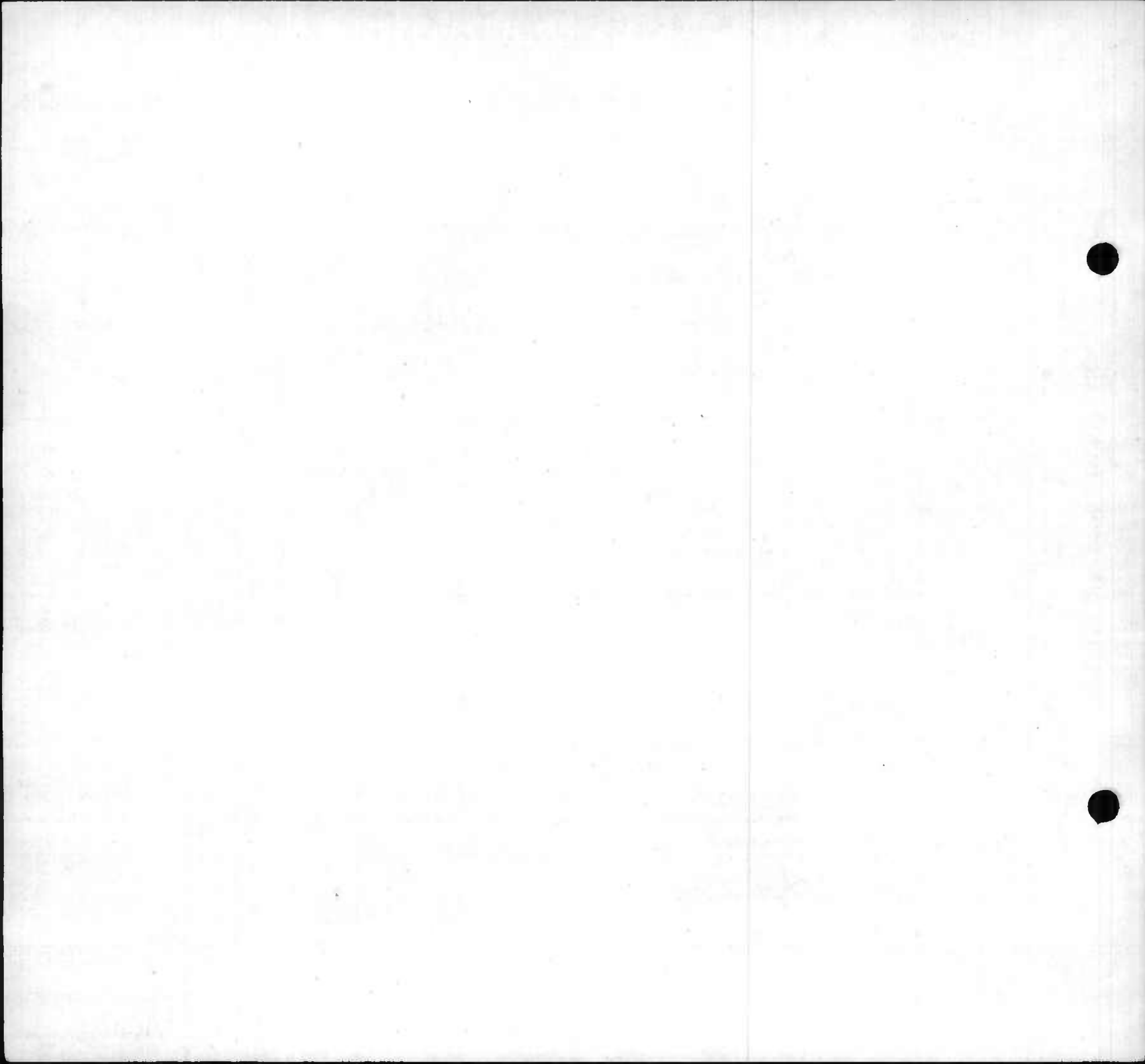
| | | | | | | | |
|---|------------------|--|---------------------------------|--|---|---|---|
| BIRTH NO. <u>66-07870</u> <u>66 04359</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. <u>66 04359</u> | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| | | <u>Ruby Bry Carlson</u> | | <u>4-17-66</u> <u>12¹⁰</u> <u>A.</u> <u>M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>UNION MEMORIAL Hospital</u> | | A. STATE <u>Md.</u> B. COUNTY <u>26-01</u> | | C. CITY OR TOWN <u>Balt.</u> (If outside city limits, write RURAL and give township) | | | |
| | | D. STREET ADDRESS <u>5823 Waycross St</u> (If rural, give location) | | | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED/DIVORCED (specify) <u>W</u> | 8. DATE OF BIRTH <u>4-16-66</u> | 9. AGE (In years last birthday) <u>1</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>B</u> | 11. BIRTHPLACE (State or foreign country) <u>USA</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | | | | | |
| 13. FATHER'S NAME <u>Robert Carlson</u> | | 14. MOTHER'S MAIDEN NAME <u>Joyce Connor</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u> </u> | | 17. INFORMANT <u> </u> | | ADDRESS <u> </u> | |
| 18. <u>762.5</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | (A) <u>Respiratory arrest</u>
DUE TO | | | | | |
| | | (B) <u>prematurity</u>
DUE TO | | | | | |
| | | (C) <u>Pulmonary atelectasis</u> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>4-16-66</u> 19 <u>66</u> to <u>4-17</u> 19 <u>65</u> , that (1) (we) last saw the deceased alive on <u>4-17</u> 19 <u>66</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Lawrence J. Casazza</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>4-17-66</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>LAWRENCE J. CASAZZA</u> | | 23D. ADDRESS <u>UNION MEMORIAL HOSP.</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u> </u> | | 24B. DATE <u>APR 29 1966</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>ANATOMY BOARD OF MARYLAND</u> | | 24D. LOCATION (City, town or county) (State) <u> </u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>APR 29 1966</u> | | 25B. NAME OF REGISTRAR <u>Ruby E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u> </u> | | ADDRESS <u> </u> | |
| | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|--|---|--|--|--|
| BIRTH NO. <u>66-06855</u> | | 66 04360 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>BRISCOE, BABY BOY</u> | | | |
| 2. DATE AND HOUR OF DEATH
<u>3/31/66</u> <u>9:00</u> P. M. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MD</u>
B. COUNTY <u>14-03</u> | | FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>UNIVERSITY HOSPITAL</u> | | | |
| 5. SEX <u>M</u> | | 6. RACE <u>N</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| 8. DATE OF BIRTH
<u>3/31/66</u> | | 9. AGE (In years last birthday)
<u>1</u> | | 10. UNDER 1 Yr. Months Days Hours Min.
<u>1</u> <u>59</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>MD.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | 13. FATHER'S NAME
<u>CLARENCE BRISCOE</u> | | 14. MOTHER'S MAIDEN NAME
<u>Minerva</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
<u>776 X I</u> | | CAUSE OF DEATH
(A) <u>Immaturity</u>
DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
<u>Birth</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/31 (8:00 PM)</u> 19 <u>66</u> to <u>3/31 (9:00 PM)</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/31</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Ruth Luddy</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>3/31/66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>RUTH LUDDY</u> | | 23D. ADDRESS
<u>University Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>APR 29 1966</u> | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY
<u>ANATOMY BOARD OF MARYLAND</u> | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 29 1966</u> | | | |
| 25B. NAME OF REGISTRAR
<u>R. E. F. J. J.</u> | | 25C. FUNERAL DIRECTOR
<u>UNIVERSITY MEDICAL SCHOOL</u> | | | |
| 25D. MORTUARY SERVICE - <u>BCHD</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04361 | |
|---|-----------|---|--|--|-------------------------------------|
| BIRTH NO. 66-08905 | | 66 04361 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) BABY GIRL DREDDEN | | 2. DATE AND HOUR OF DEATH 4/25/66 5:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 17-02 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 1134 57th St Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 7 MERCY HOSPITAL | | D. STREET ADDRESS (If rural, give location) 1134 57th St | | 9. AGE (In years last birthday) 4/24/66 | |
| 5. SEX A F | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) S | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 11. BIRTHPLACE (State or foreign country) Ba U.S.A. | 12. CITIZEN OF WHAT COUNTRY? 4-8-A- |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Alice Dredden | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | |
| 19. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/24 1966 to 4/25 1966, that (I) (we) last saw the deceased alive on 4/25 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Inelda B. Salanio | | 23B. DATE SIGNED 4/27/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS Mercy Hospital, Balto. 21202 | | 23E. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE APR 29 1966 | | 24C. NAME OF CEMETERY OR CREMATORY | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 29 1966 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REGISTERED NO. 4659456A2 E4 | |
|--|--|--|--|--|--|
| BIRTH NO. 66-4362 | | | | M.E. CASE NO. 66-07546 | |
| CERTIFICATE OF DEATH | | | | 66-4362 | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | |
| BOLNER, BABY GIRL | | 11:45 AM 4/15/66 M. | | FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | |
| Union Memorial Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 5. SEX F 6. RACE W | |
| A. STATE MARYLAND | | B. COUNTY | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | D. STREET ADDRESS (If rural, give location) | | 8. DATE OF BIRTH | |
| BALTIMORE, MD. 21218 | | 1716 N CALVERT ST. | | 4/14/66 | |
| 9. AGE (In years last birthday) | | 10. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 12 days | | U.S. Post Office | | Union Memorial Hospital | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| U.S. | | CARL Edward Bohner | | BETTY WAE SHANSHOLTZ | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) Prematurity | | — | |
| ANTECEDENT CAUSES | | (B) Pulmonary Atelectasis R.L. | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 4/14 1966 to 4/15 1966, that (we) last saw the deceased alive on 4/15 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | 23A. SIGNATURE | | 23B. DATE SIGNED | |
| A. Harold Lubin | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> Intern <input checked="" type="checkbox"/> | | 4/15/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| A. HAROLD LUBIN | | M.D. Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| | | APR 29 1966 | | JOHNS HOPKINS MEDICAL SCHOOL | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| APR 29 1966 | | Robert E. Farber | | MORTUARY SERVICE - BCHD | |

Belmont Atlantic

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66-08444 66 04363 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04363 | |
|--|---------------------|--|--|--|---------------------------------|--|--|
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Baby Girl Breeding | | | | Apr 24, 1966 18:05 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Union Memorial Hosp.
(If not in hospital or institution, give street address or location)
Baltimore, Md. | | | | A. STATE Virginia
B. COUNTY Prince William | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Woodbridge | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
92 Occoquan Road | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
NEVER MARRIED | | 8. DATE OF BIRTH
Apr 24, 1966 | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
INFANT | | | | 10B. KIND OF BUSINESS OR INDUSTRY
NONE | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Ronald Breeding | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | | | 16. SOCIAL SECURITY NO.
N.A. | | 17. INFORMANT
Marian Yoast | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
773.51
Hyaline Membrane Disease
PREMATURITY
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
5 1/2 hrs. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Apr 24 19 66 to Apr 24 19 66 , that (I) (we) last saw the deceased alive on Apr 24 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Robert G. Thompson | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> House Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
24 Apr, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
Robert G. Thompson | | | | 23D. ADDRESS
THE UNION MEMORIAL HOSPITAL
Union Memorial Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
APR 29 1966 | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY
JOHNS HOPKINS MEDICAL SCHOOL | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | 25B. NAME OF REGISTRAR
J. E. Johnson | | 25C. FUNERAL DIRECTOR
MORTUARY SERVICE - BCHD | | ADDRESS | |

FUNERAL DIRECTOR: IMPORTANT

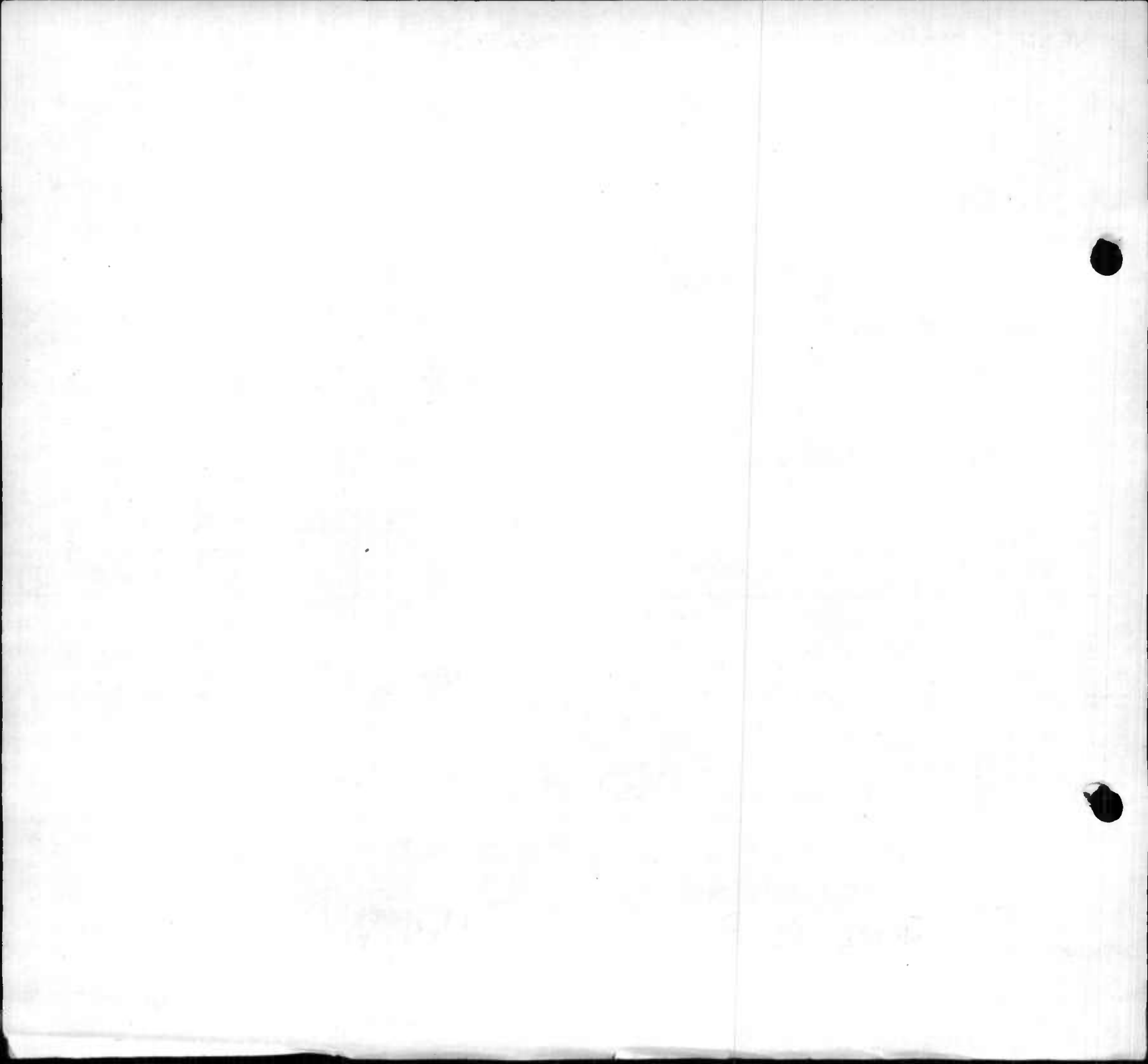
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------------|---|--|---|--|--|---|------------------------------------|--|
| BIRTH NO. 66-6835466 04364 | | | | | REGISTERED NO. 66 04364 | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) BABY BOY BURKE | | | | | 2. DATE AND HOUR OF DEATH
4-21-66 7:10 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
UNIVERSITY OF MARYLAND HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 2607 SPELMAN RD. | | | | |
| 5. SEX
M | 6. RACE
N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
NEVER MARRIED | 8. DATE OF BIRTH
4-20-66 | | 9. AGE (In years last birthday)
20 | | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min.
7 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | | 10B. KIND OF BUSINESS OR INDUSTRY
NONE | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
HERBERT BURKE | | | | | 14. MOTHER'S MAIDEN NAME
SHIRLEY LOCUST | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT ADDRESS
HOSPITAL CHART | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ATALECTASIS
(A) DUE TO
PREMATURITY
(B) DUE TO
(C) _____

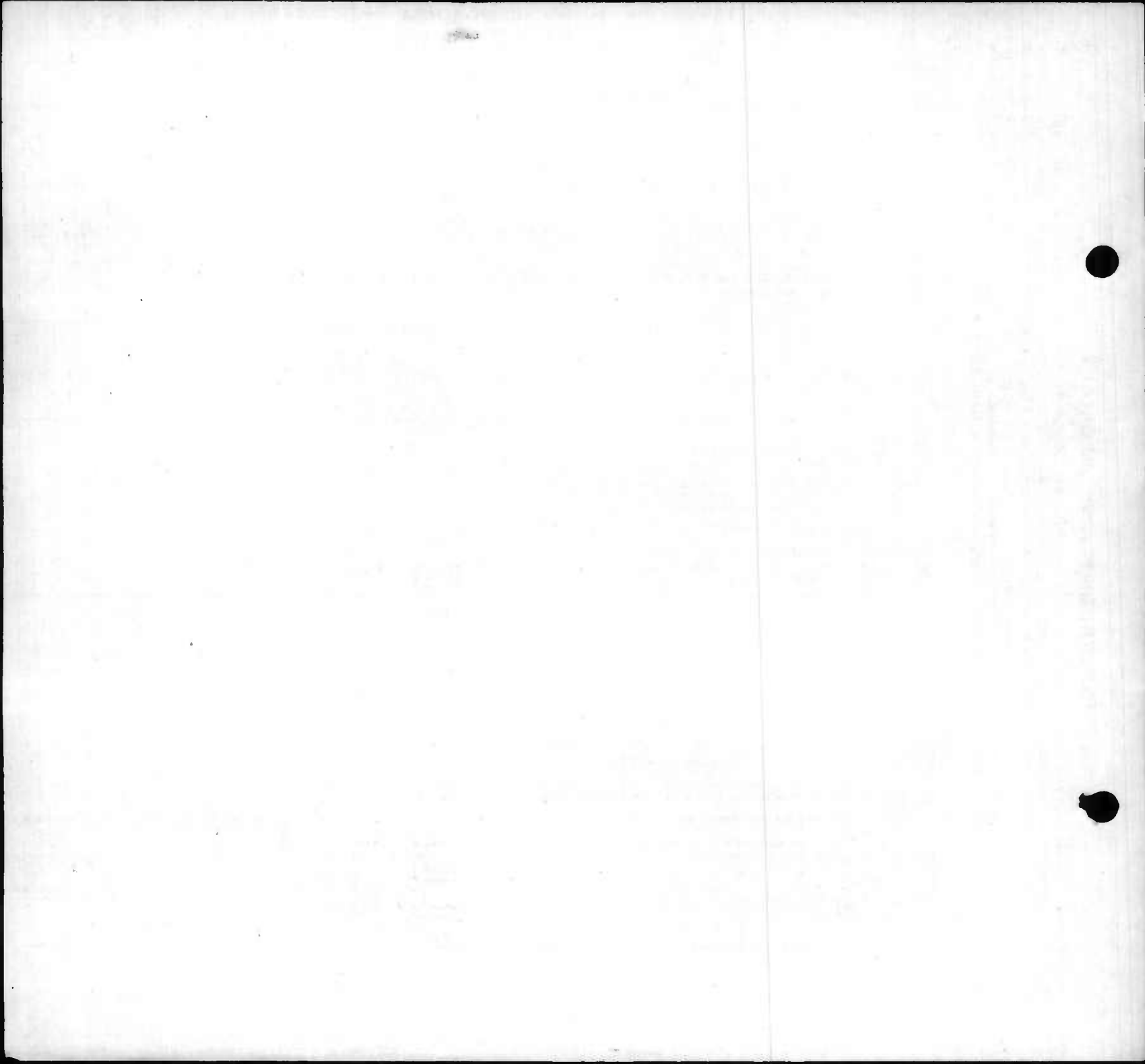
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
PREMA. | | | | | INTERVAL BETWEEN ONSET AND DEATH
20 hr | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from APRIL 20 1966 to APRIL 21 1966 , that (I) (we) last saw the deceased alive on APRIL 21 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Joyce M. Boyd | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
4-21-66 | |
| 23C. PHYSICIAN'S NAME (Type)
JOYCE M. BOYD | | | | | 23D. ADDRESS
UNIVERSITY HOSPITAL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
APR 29 1966 | | 24C. NAME OF CEMETERY OR CREMATORY
JOHNS HOPKINS MEDICAL SCHOOL | | 24D. LOCATION (City, town or county) (State)
MORTUARY SERVICE - BCBH | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | 25B. NAME OF REGISTRAR
Robert E. Farley | | | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



The body of John DeYoung was released to the Johns Hopkins Hospital on approval by Dr. Britnecker.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--------------|---|----------------------------|---|---|
| BIRTH NO. 66 04366 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04366 | |
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) De Young John | | 2. DATE AND HOUR OF DEATH
1130 AM 4/27/66 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Johns Hopkins Hosp.
Baltimore 5 Md. | | A. STATE Md
B. COUNTY City 27-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore Md :06
D. STREET ADDRESS (If rural, give location)
6310 Elinore Ave | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
1-1-08 | 9. AGE (In years last birthday)
58 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mechanic | | 10B. KIND OF BUSINESS OR INDUSTRY
Southern Sales Co. | | 11. BIRTHPLACE (State or foreign country)
Sheboygan Wis. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Cornelius DeYoung | | | |
| 14. MOTHER'S MAIDEN NAME
Marie Vankreeke Vanderkreeke | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
39661-8566 | | 17. INFORMANT
Mrs Aurelia DeYoung 6310 Elinore Avenue | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Myocardial Infarction 3 1/2 h
Arteriosclerosis
General Anesthesia 3 1/2 h | | CAUSE OF DEATH
INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Urethral Structure B.P.H. | | | |
| 19A. DATE OF OPERATION
4/27 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Urethral Structure BPH | | 20A. AUTOPSY? (Yes or No)
YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/21 1966 to 4/27 1966, that (I) (we) lost saw the deceased alive on 4/27 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE
R. W. Bridge | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/27 | |
| 23C. PHYSICIAN'S NAME (Type)
R. W. Bridge | | 23D. ADDRESS
Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-30-1966 | | 24C. NAME OF CEMETERY or CREMATORY
Gardens of Faith Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | | |
| 25B. NAME OF REGISTRAR
A. E. F. | | 25C. FUNERAL DIRECTOR
Lassahn Funeral Home 7401 Belair Rd | | | |

Discontinued
1/1/19

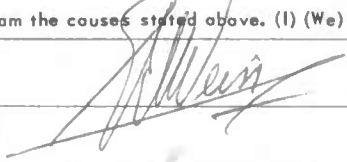
254

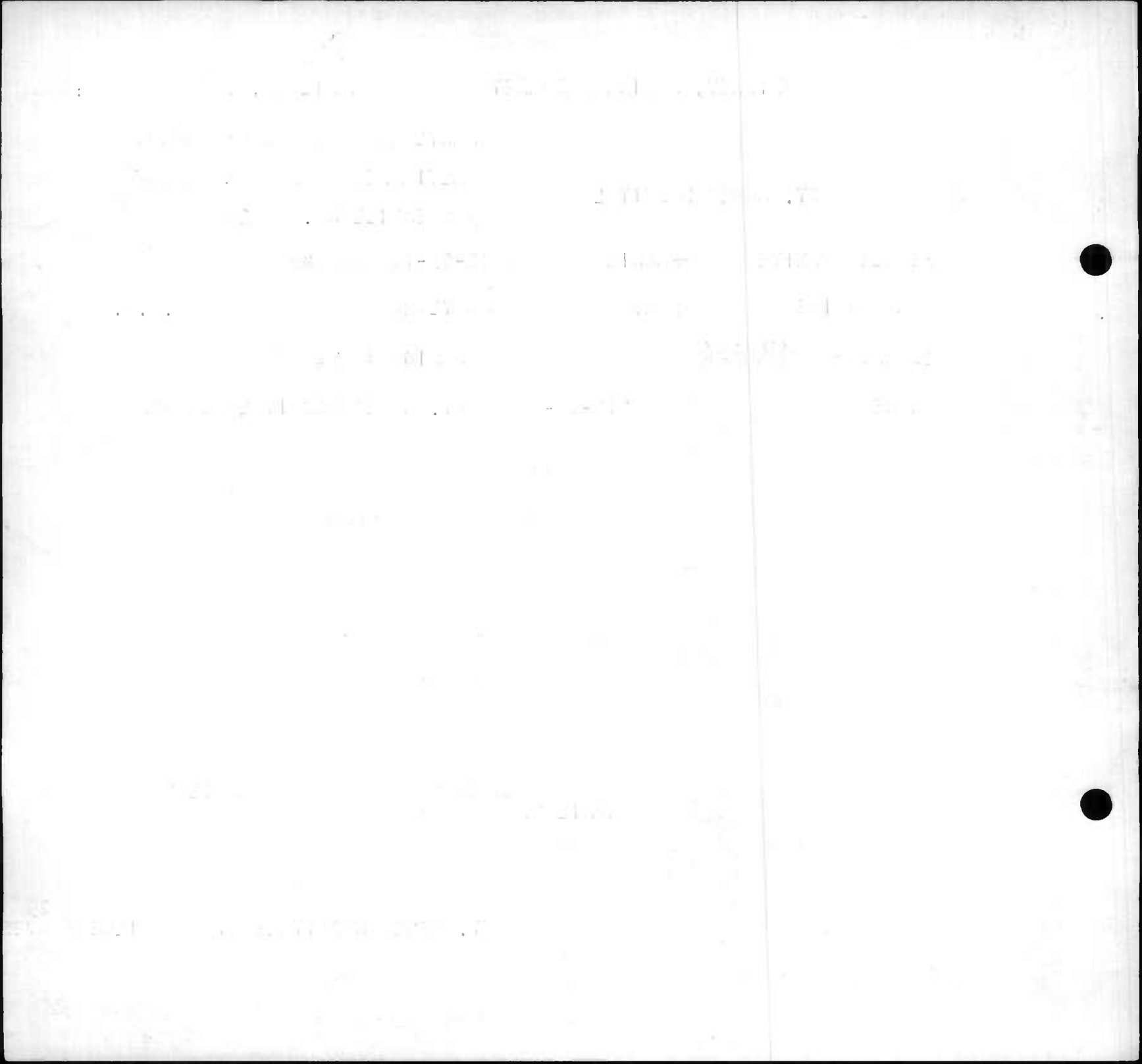
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04367 | |
|--|-------------------------|--|---|--|---|
| BIRTH NO. 66 04367 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) FRISKEY, MARIAN MARGARET | | 2. DATE AND HOUR OF DEATH
APRIL 27, 1966 6:45A. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
ST. AGNES HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTO. CO.
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE, CATONSVILLE 5300
D. STREET ADDRESS (If rural, give location)
5 OVERHILL RD. #28 | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
12-23-16 | 9. AGE (In years last birthday)
49 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
NONE | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 13. FATHER'S NAME
EDWARD H. DUNKER | | | 14. MOTHER'S MAIDEN NAME
MARIAN i SCOTT | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NONE | | 16. SOCIAL SECURITY NO.
212-09-6980 | | 17. INFORMANT
ST. AGNES HOSPITAL RECORDS | |
| 18. 201X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTecedent CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Colibacilemia | | CAUSE OF DEATH
(A) DUE TO Bone Marrow Depression & Anemia
Leukopenia and Thrombocytopenia
(B) DUE TO Hodgkins Disease
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MARCH 28 19 66 to APRIL 27 19 66 , that (I) (we) last saw the deceased alive on APRIL 27 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
 | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
Robert E. Farber, M.D. | | 23D. ADDRESS
M.D. ST. AGNES HOSPITAL; CATON & WILKENS AVES #29 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/29/66 | | 24C. NAME of CEMETERY or CREMATORY
LOUDON PARK | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE MD. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR
A.S. MACNABB 301 FREDERICK RD 21228 | | | |



ON APPROVAL BY THE MEDICAL EXAMINER
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04368 | |
|--|---------|--|------------------|--|------------------------------|
| 66 04368 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | George Russel | | April 27, 1966 10:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | Maryland | | B. COUNTY | |
| South Baltimore General Hospital | | Baltimore 30 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| 1213 Light Street, Baltimore 30 | | 1118 Carroll Street | | D. STREET ADDRESS (If rural, give location) | |
| Maryland | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| Male | White | Married | 2/22/1879 | 86 87 | U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Carpenter | | Chesapeake & Maryland Railway | | Md. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Roland F. Russell | | Anna Graves | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| no | | 12-5809 | | Mrs. Blanche R. Russel | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g. heart failure, oshtenio, etc. It means the disease injury or complication which caused death.) | | (A) Bronchopneumonia | | | |
| ANTECEDENT CAUSES | | (B) 1st to 3rd Degree Burns 28.5 % | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (C) | | | |
| II | | Congestive Heart Failure | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | Home | | 1118 Carroll St., Baltimore 30, Md. | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| April 19, 1966 A.M. | | While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | Patient was smoking in bed when bed sheets caught fire. | |
| 22. I certify that (I) (this hospital) attended the deceased from April 19 19 66 to April 27 19 66, that (I) (we) last saw the deceased alive on April 27 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Consolador C. Pa lad, Jr. | | | | April 28, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| S.B.G.H., 1213 Light St., Baltimore 30, Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 4/30/66 | | Lorraine Park Cem | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| APR 29 1966 | | John E. Taylor, Jr. | | John J. Gowan & Son Inc | |
| | | | | ADDRESS | |
| | | | | St. Johns | |

yes

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

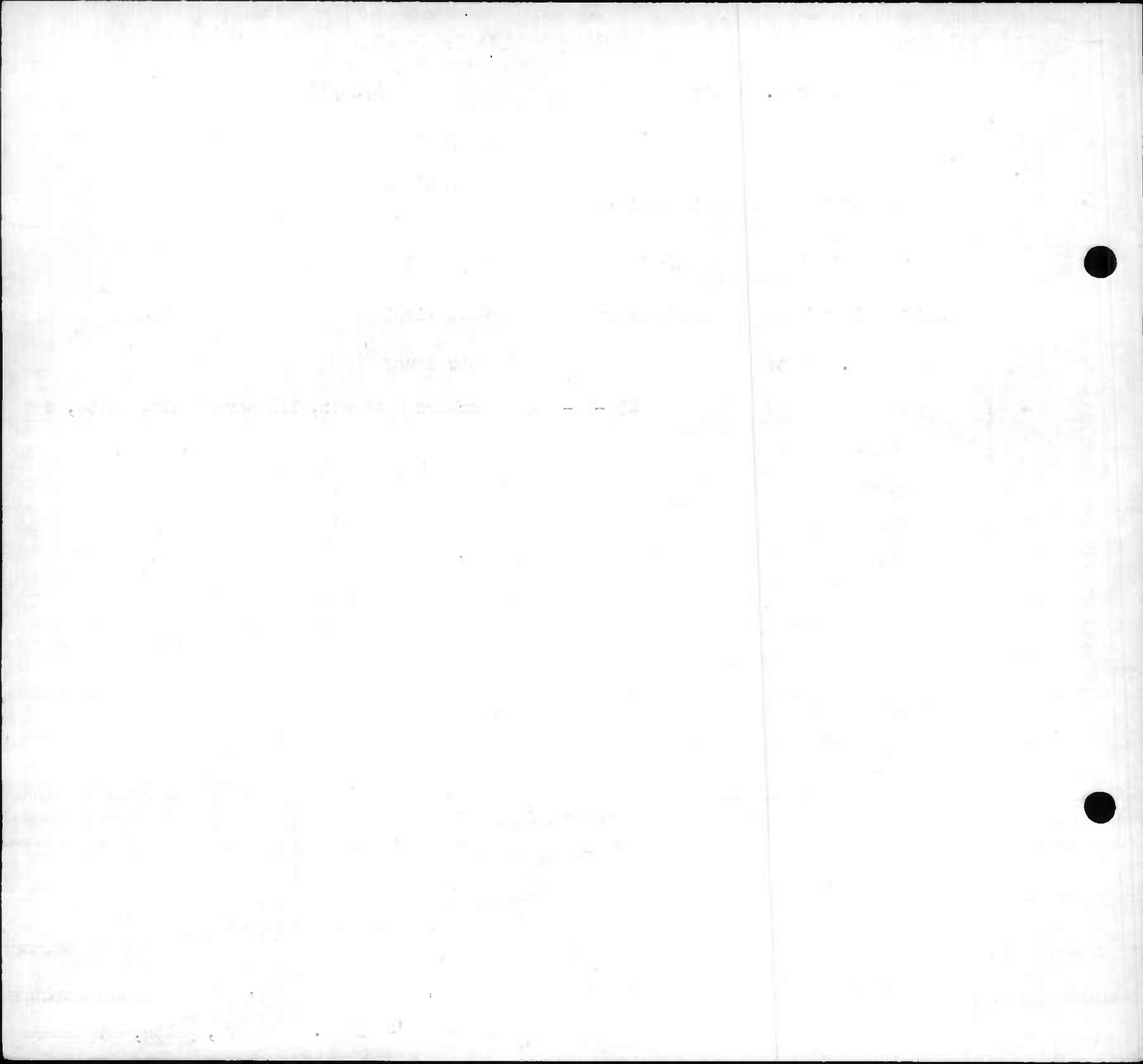
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>66 04369</u> | |
|--|-------------------------|---|--|--|---|---|--|
| BIRTH NO. <u>66 04369</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>James T. Sheets</u> | | 2. DATE AND HOUR OF DEATH
<u>4/26/66</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>South Baltimore General Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Md</u>
B. COUNTY <u>22-01</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u>
D. STREET ADDRESS (If rural, give location)
<u>114 Warren Ave</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>12/25/21</u> | 9. AGE (In years last birthday)
<u>44</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Self Employed</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Auto Sales</u> | | 11. BIRTHPLACE (State or foreign country)
<u>West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>Thomas M. Sheets</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Etta Young</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>yes WWII</u> | | | 16. SOCIAL SECURITY NO.
<u>235-30-8585</u> | | 17. INFORMANT
<u>Barbara M Sheets, 114 Warren Ave, Balto, Md</u> | | ADDRESS |
| 18. <u>322.21</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) <u>Aspiration of vomitus into tracheobronchial tree due to</u>
(B) <u>alcoholism</u>
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/25/66</u> 19 to <u>4/26/66</u> 19, that (I) (we) last saw the deceased alive on <u>4/26/66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Ricardo Lozada</u> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>4/27/66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>RICHARDO LOZADA</u> | | | | 23D. ADDRESS
M.D. <u>1225 S. Charles H. Balto Md 21220</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/29/66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Baltimore National Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 29 1966</u> | | | | 25B. NAME OF REGISTRAR
<u>Robert C. Jones</u> | | 25C. FUNERAL DIRECTOR
<u>McCully's 130 E. Fort Ave, Balto, Md</u> | |



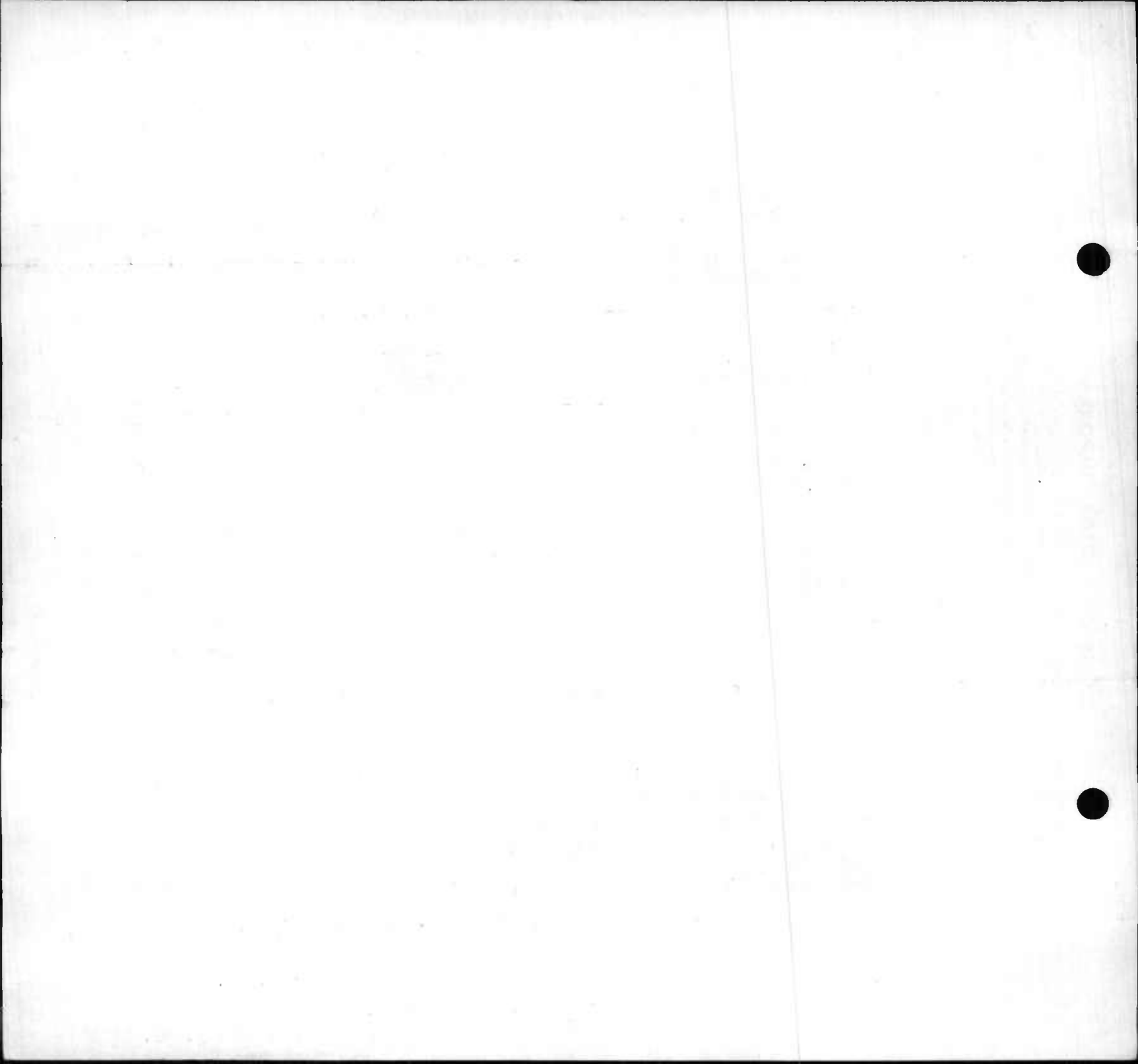
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 04370 | |
|--|------------------|---|------------------------------------|--|---|--|--|
| BIRTH NO.
66 04370 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print)
Anna Polly Woods | | 2. DATE AND HOUR OF DEATH
April 26, 1966 2 p M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Long Green Nursing Home
115 E. Melrose Avenue
Baltimore, Md. 21212 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 5810 Gwyn Oak Avenue | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
Sept. 27, 1886 | 9. AGE (In years last birthday)
79 | 10. If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10B. KIND OF BUSINESS OR INDUSTRY
-- | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John Bittel | | | | 14. MOTHER'S MAIDEN NAME
Mary Herbig | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-01-2945 | | 17. INFORMANT
Katherine W. Hess (Sister-in-law)
2804 Maryland Ave. Balto. Md. 21218 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) DUE TO
Cerebral Hemorrhage
Pulmonary edema
(B) DUE TO
Cardio Vascular Disease
arterio Sclerosis
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
Sudden
Chronic | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 16 1964 to Apr 26 1966, that (I) (we) last saw the deceased alive on Apr 26 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
George McLean | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
Apr 27-66 | |
| 23C. PHYSICIAN'S NAME (Type)
George McLean | | 23D. ADDRESS
M.D. Medical Arts Bldg. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/29/1966 | | 24C. NAME OF CEMETERY or CREMATORY
Lounoun Park Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | 25B. NAME OF REGISTRAR
Robert E. Seitz | | 25C. FUNERAL DIRECTOR
Eugenia K. Seitz | | ADDRESS
5209 York Road
Seitz Funeral Home Balto. Md. 21212 | |

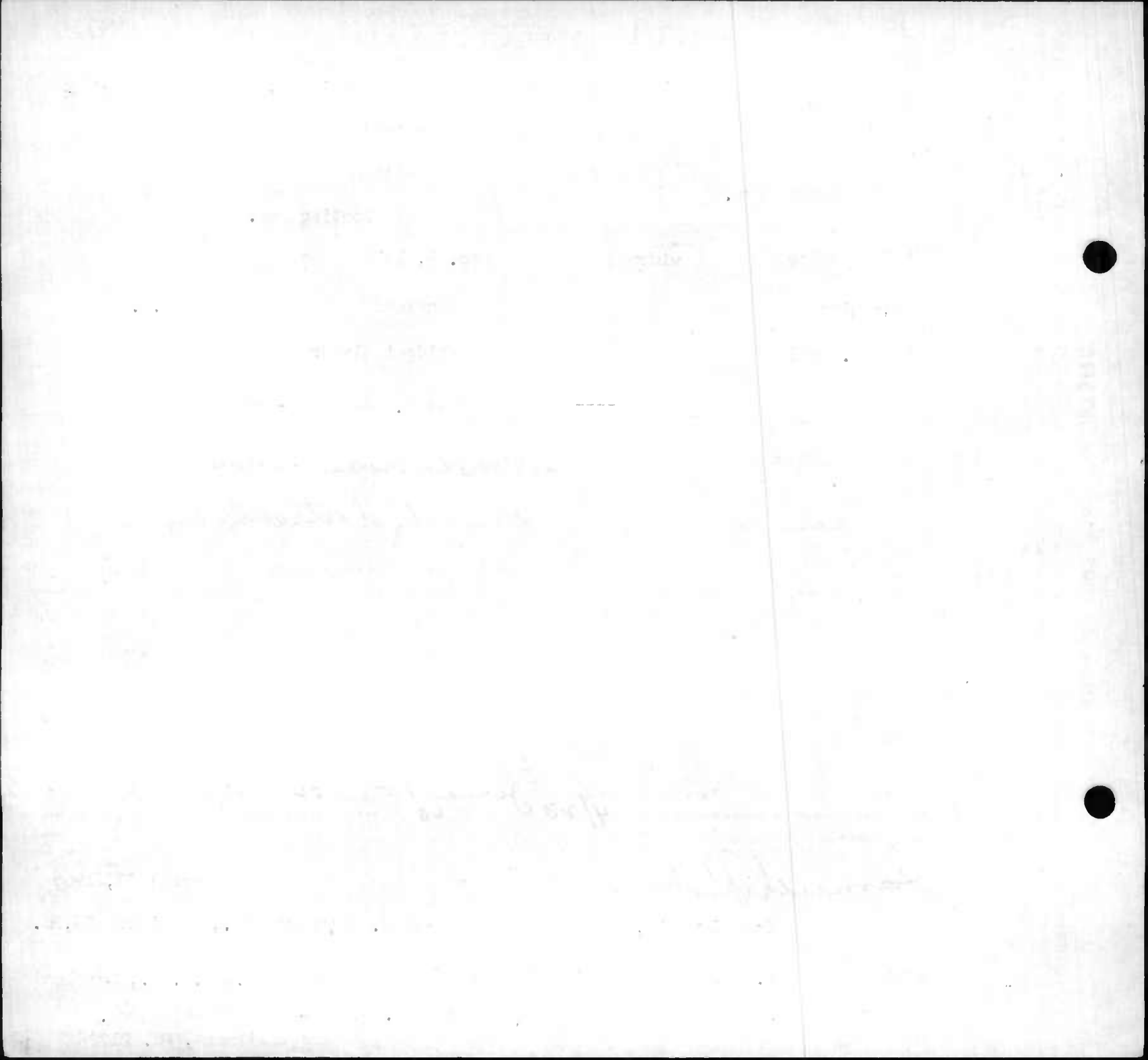


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 04371</u> | |
|--|-------------------------|---|---|---|--|
| BIRTH NO. <u>66 04371</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>MARY ELIZABETH AKEHURST</u> | | 2. DATE AND HOUR OF DEATH
<u>April 25, 1966</u> <u>8 4</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>819 Pontiac Ave.</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>25-04</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u>
D. STREET ADDRESS (If rural, give location)
<u>819 Pontiac Ave.</u> | | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>widowed</u> | 8. DATE OF BIRTH
<u>Dec. 9, 1876</u> | 9. AGE (In years last birthday)
<u>89</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>England</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | 13. FATHER'S NAME
<u>John T. Malloy</u> | | 14. MOTHER'S MAIDEN NAME
<u>Bridget Slater</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>----</u> | | 17. INFORMANT
<u>Thomas J. Akehurst - same</u> | |
| 18. <u>420.01</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>arteriosclerotic Heart Disease</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Generalized arteriosclerosis</u> | | CAUSE OF DEATH
(A) <u>arteriosclerotic Heart Disease</u>
DUE TO
(B) <u>Generalized arteriosclerosis</u>
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>4/23</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
III in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1956</u> to <u>April 25, 1966</u> , that (I) (we) last saw the deceased alive on <u>4/23</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Samuel Rubin</u> | | | | 23B. DATE SIGNED
<u>April 25, 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Samuel Rubin,</u> | | 23D. ADDRESS
<u>201 E. Patapsco Ave., Baltimore 25, Md.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>Apr. 28, '66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Cedar Hill Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Ritchie Hgwy., A.A.Co., Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 29 1966</u> | | | |
| 25B. NAME OF REGISTRAR
<u>R. E. Fisher, MD</u> | | 25C. FUNERAL DIRECTOR
<u>George J. Gonce - 4001 Ritchie Hgwy.</u> | | | |
| 25D. ADDRESS
<u>Baltimore, Md. 21225</u> | | | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN E. JEETER

2. DATE AND HOUR PRONOUNCED DEAD

April 26, 1966 3:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where decedent lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3824 Second Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

March 23, 1920

9. AGE (In years
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Dockman

10B. KIND OF BUSINESS OR INDUSTRY

Md. Drydock

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Samuel J. Jeeter

14. MOTHER'S MAIDEN NAME

Susan C. McGarrity

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

217-07-2642

17. INFORMANT

Mrs. Doris Jeeter

ADDRESS

Same

18. E902.3

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Cranio-cerebral injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

dry dock

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

Md. Dry Dock & Ship Building Co.

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

4-26-66

3:10 P

21E. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

Fell 40' from dry dock

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-27-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

April 30, 1966

23C. NAME OF CEMETERY or CREMATORY

Cedar Hill Cemetery

23D. LOCATION

(City, town, or county)

Ritchie Hwy. A. A. Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

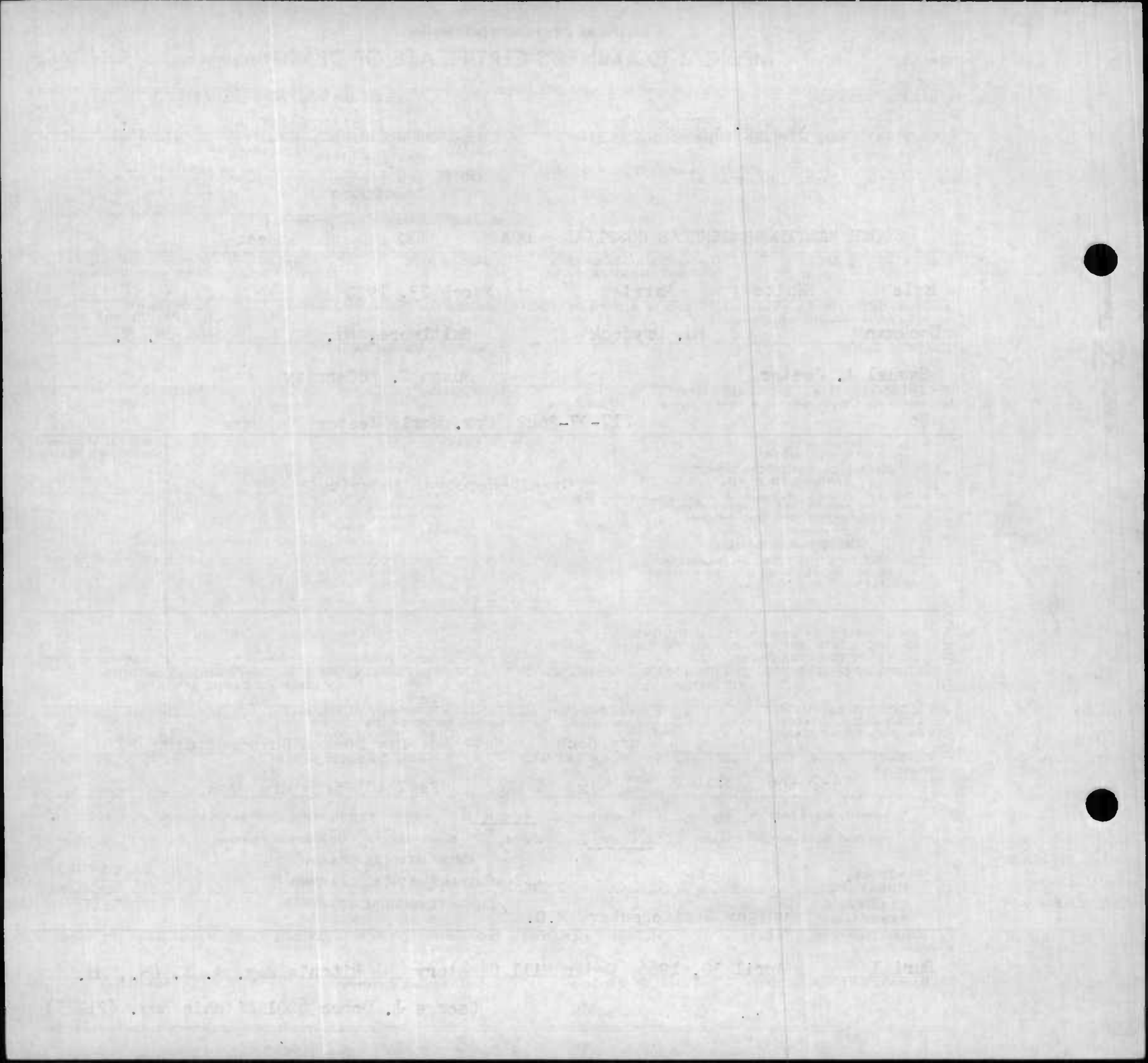
APR 29 1966

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

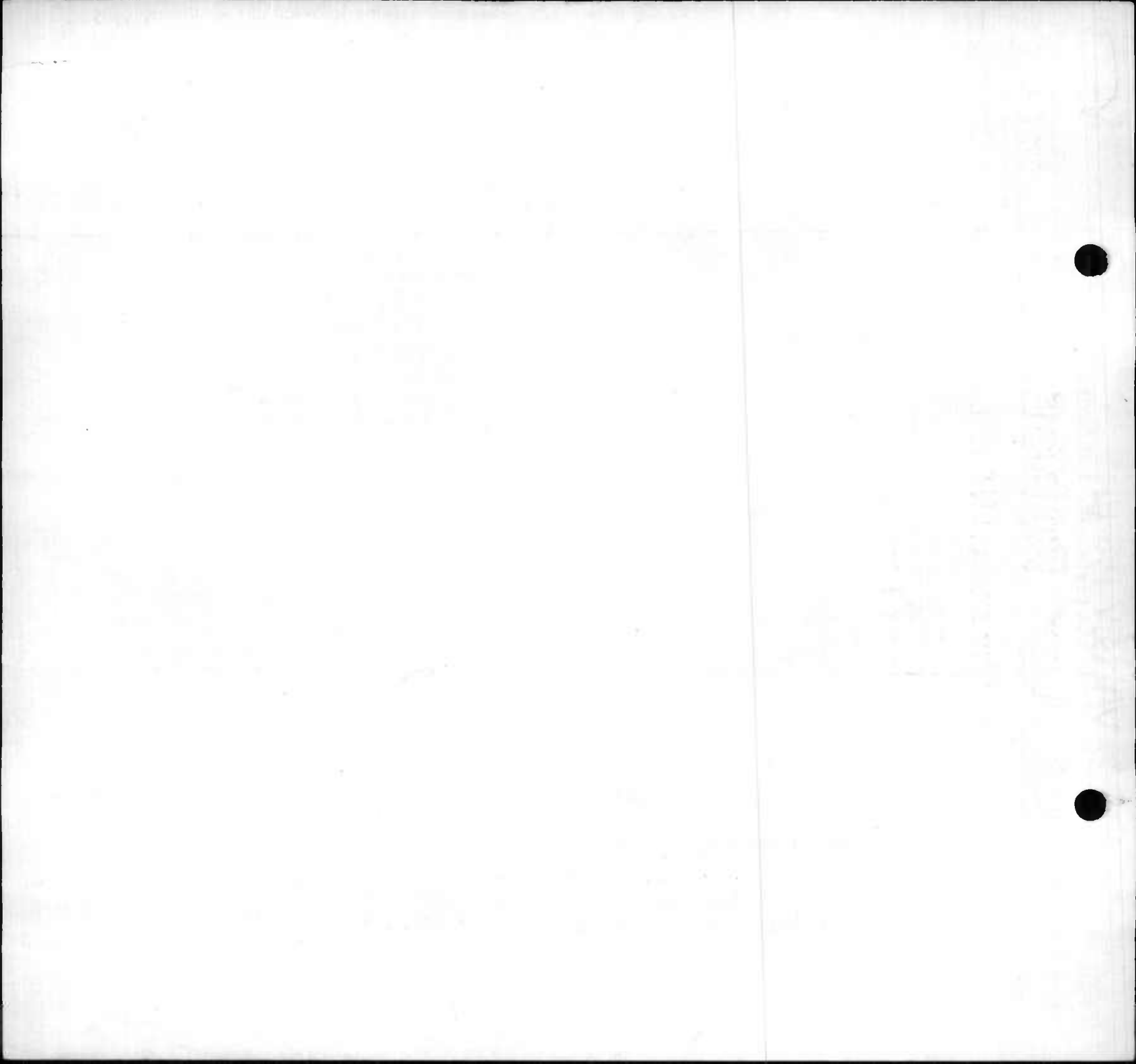
George J. Gonce 4001 Ritchie Hwy. (21225)



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

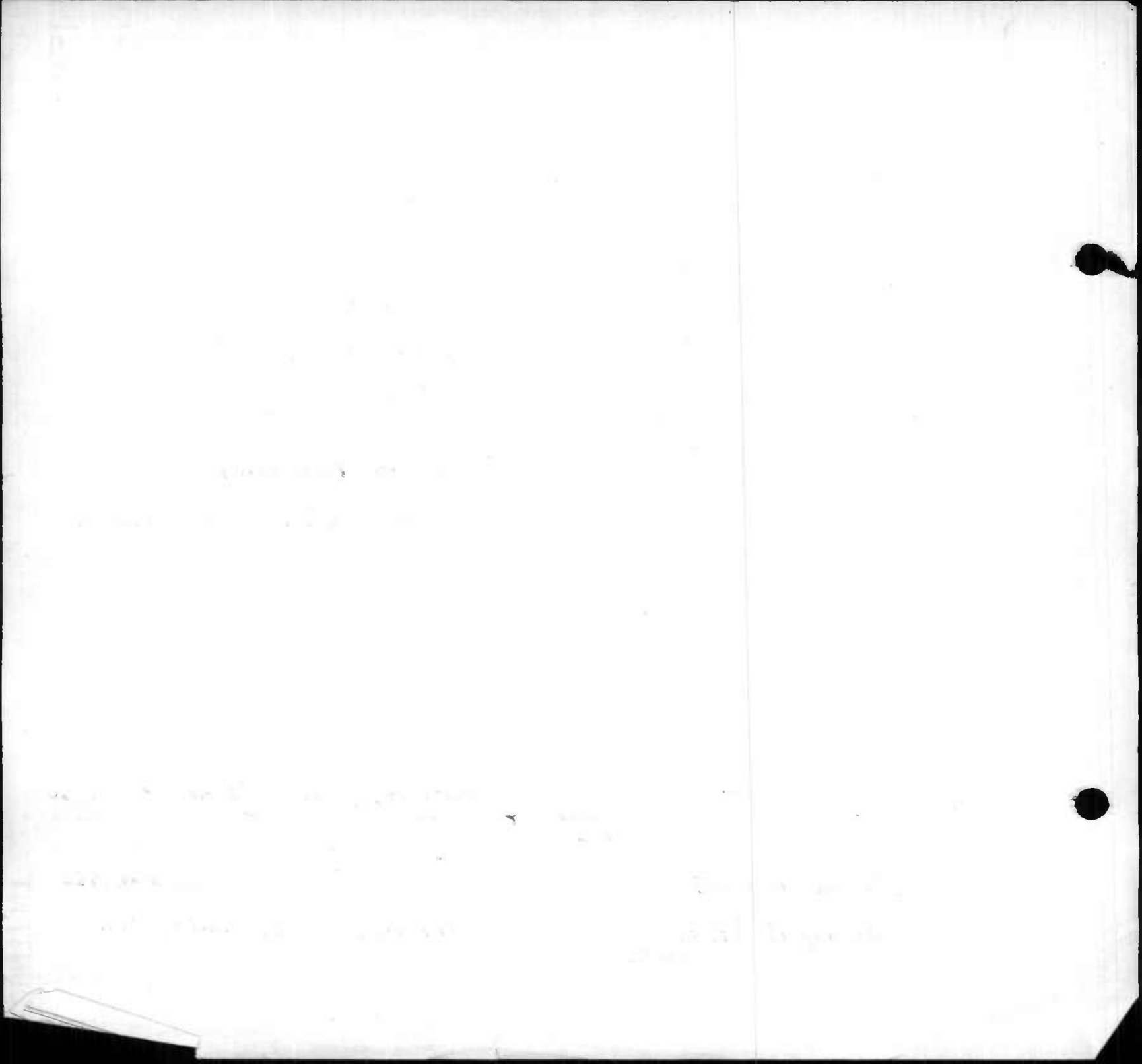
| | | | |
|---|---|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04373 | |
| BIRTH NO. 66 04373 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) <i>Albert Estee</i> | | <i>April 27, 1966</i> 50. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE <i>Maryland</i> 4-02 | |
| <i>Montebello Hosp.</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| | | <i>Baltimore</i> | |
| | | D. STREET ADDRESS (If rural, give location) | |
| | | <i>511 W. Mulberry St.</i> | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH <i>6-25-1897</i> |
| | | | 9. AGE (In years last birthday) <i>68</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | |
| <i>Labor</i> | | <i>California</i> | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| <i>Tully Estee</i> | | <i>Lucinda Weaver</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>079-14-6399</i> | |
| | | 17. INFORMANT ADDRESS | |
| | | <i>Hospital Chart -</i> | |
| 18. <i>260X I</i> | | CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | <i>Diabetes Mellitus -</i> | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | <i>years</i> | |
| ANTECEDENT CAUSES | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| II | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| <i>0</i> | | <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | |
| | While At <input type="checkbox"/> Not While <input type="checkbox"/>
Work At Work <input type="checkbox"/> | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>April 20, 1966</i> to <i>April 27, 1966</i> , that (I) <i>we</i> lost saw the deceased alive on <i>April 27, 1966</i> and that in (my) <i>our</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>We</i> (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>Cesar J. Pellorano</i> M.D. | | 23B. DATE SIGNED <i>April 27, 1966</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Cesar J. Pellorano</i> | | 23D. ADDRESS <i>Montebello Hospital</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>APR 29 1966</i> | | 24B. NAME OF CEMETERY OR CREMATORY <i>JOHNS HOPKINS MEDICAL SCHOOL</i> | |
| 24C. DATE REC'D BY HEALTH DEPT. <i>APR 29 1966</i> | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25B. FUNERAL DIRECTOR ADDRESS | |
| | | <i>MORTUARY SERVICE - BCHO</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|---|----------------------|--|---|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | Registered No. 66 04374 | |
| BIRTH NO.
66 04374 | | M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Madeline Helweick</i> | | | | | | 2. DATE AND HOUR OF DEATH
<i>Apr. 26/66</i> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Md</i> B. COUNTY <i>Balto</i> | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>St. Agnes Hospital</i> | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Balto 27 53-00</i> | | | | | |
| D. STREET ADDRESS (If rural, give location)
<i>248 Clyde Ave</i> | | | | | | | | | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>W.</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Widowed</i> | | 8. DATE OF BIRTH
<i>Aug 26/91</i> | | 9. AGE (In years last birthday)
<i>74</i> | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>H.W.</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Own Home</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Md</i> | | | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>Anton Meier</i> | | | | | | 14. MOTHER'S MAIDEN NAME
<i>Margaret Engle</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Henry Meier, 248 Clyde Ave</i> | | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
<i>Anteroselective Cardio-vas. Dis.</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>Unknown</i> | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | |
| II | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION
<i>4/22/66</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Oct. 14, 1966</i> to <i>April 8, 1966</i> , that (I) (was) last saw the deceased alive on <i>April 8, 1966</i> and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
<i>Edward F. Potter</i> | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED
<i>April 29, 1966</i> | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Edward F. Potter</i> | | | | | | 23D. ADDRESS
M.D. <i>827 LINDEN AVE. BALTO. MD.</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | 24B. DATE
<i>4/30/66</i> | | | 24C. NAME OF CEMETERY or CREMATORY
<i>Lorraine Park</i> | | | 24D. LOCATION (City, town, or county) (State)
<i>Balto. 7. Md</i> | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>APR 29 1966</i> | | | 25B. NAME OF REGISTRAR
<i>R. E. E. Farber, MD</i> | | | 25C. FUNERAL DIRECTOR
<i>Witzke & Co.</i> | | | ADDRESS
<i>4101 Edmondson Ave</i> | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HANNAH

McKNIGHT

2. DATE AND HOUR PRONOUNCED DEAD

April 25, 1966

6:15 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2003 Druid Hill Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

5/6/47

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

Annie Hatfield

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Miss Bessie McKnight 2003 Druid Hill Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/26/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/25/66

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 29 1966

Adolphus Halstead 1206 W North Ave



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|--|--|--|--|---|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>66 04376</u> | | | | |
| BIRTH NO. <u>66 04376</u> | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>JOHN SAMUEL EDWARDS</u> | | | | | 2. DATE AND HOUR OF DEATH
<u>APRIL 26, 1966 12:10 P.M.</u> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE <u>MD</u> B. COUNTY <u>4-02</u> | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>UNIVERSITY OF MARYLAND HOSPITAL</u> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
<u>254 N. PINE ST.</u> | | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>NEGRO</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>5-13-99</u> | 9. AGE (In years last birthday)
<u>66</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>NONE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>NONE</u> | | 11. BIRTHPLACE (State or foreign country)
<u>NORTH CAROLINA</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 13. FATHER'S NAME
<u>SAMUEL EDWARDS</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>UNKNOWN</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>UNKNOWN</u> | | | 16. SOCIAL SECURITY NO.
<u>UNKNOWN</u> | | 17. INFORMANT ADDRESS
<u>WIFE SAME AS ABOVE</u> | | | | |
| 18. <u>155.0 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>CAUSE OF DEATH</u>
<u>METABOLIC DERANGEMENTS</u>
(A) <u>UNKNOWN</u>
(B) <u>PRIMARY HEPATOMA</u>
(C) <u>UNKNOWN</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>UNKNOWN</u> | | | | | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>NONE</u> | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>APRIL 25, 1966</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>GASTROINTESTINAL TRACT PHASE</u> | | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>NO</u> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<u>NO</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<u>—</u> | | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
<u>—</u> | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
<u>—</u> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR?
<u>—</u> | | | | |
| 22. I certify that the <u>this hospital</u> attended the deceased from <u>APRIL 23,</u> 19 <u>66</u> to <u>APRIL 26</u> 19 <u>66</u> , that we <u>(we)</u> last saw the deceased alive on <u>APRIL 26,</u> 19 <u>66</u> and that in my <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (We) <u>(We)</u> (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<u>John C. Dummer, Jr.</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
<u>APRIL 26, 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>JOHN C. DUMMER, JR.</u> | | | | | 23D. ADDRESS
M.D. <u>UNIVERSITY OF MD, HOSPITAL</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/30/66</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>MT. CALVERY</u>
St. Auburn Cemetery | | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore Md</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 29 1966</u> | | | 25B. NAME OF REGISTRAR
<u>P. D. A. E. F. DUMMER</u> | | | 25C. FUNERAL DIRECTOR ADDRESS
<u>Adolphus Halstead 1206 W North Ave</u> | | | |

UNIVERSITY OF MD. HOSPITAL

JOHN C. DUNCAN, JR.

John C. Duncan, Jr.

APRIL 26

APRIL 26

APRIL 26

APRIL 26

NO

APRIL 26 THE CONSTITUTIONAL AND LEGAL

NAME

PRIMARY HEPATOMA

RETROPERITONEAL DEGENERATION

WIFE

SAME AS ABOVE

SAMUEL EDWARDS

UNKNOWN

NONE

NONE

NORTH CAROLINA

MARRIED

NONE

M

254 N. FIVE ST.

BALTIMORE

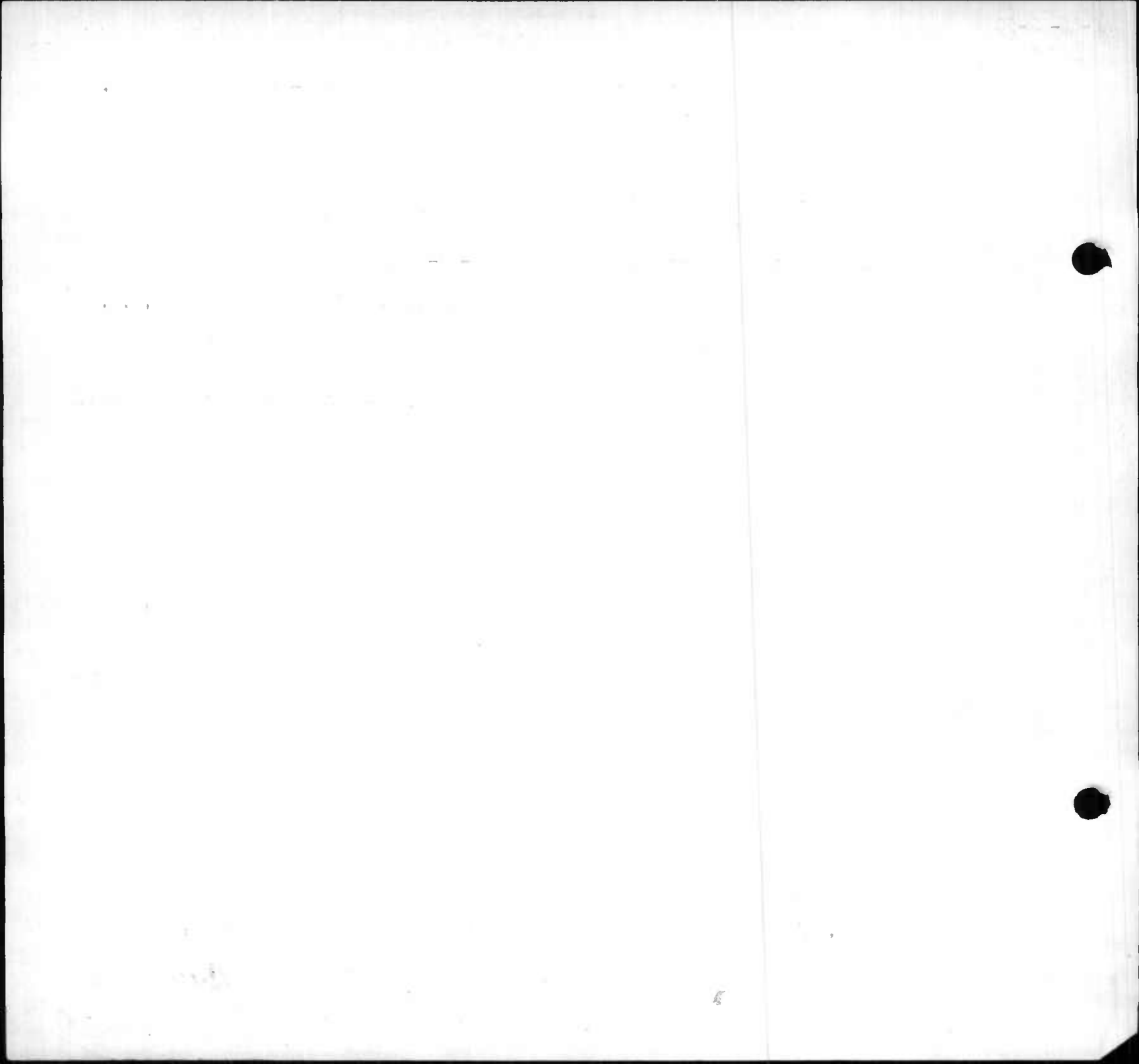
UNIVERSITY OF MARYLAND
HOSPITAL

SAB-46-12-50
T.6

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------|---|----------------------------|--|---|
| BIRTH NO. 66 04377 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04377 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Mary Leazer Torrence
Mary Torrence | | 2. DATE AND HOUR OF DEATH 4-26-1966 | | 5.00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | A. STATE Maryland
B. COUNTY 25-06
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
3301 Tate Street 21226 | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 3-15-1880 | 9. AGE (In years last birthday) 86 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) South Carolina | |
| 13. FATHER'S NAME Andrew Smarr | | 14. MOTHER'S MAIDEN NAME Sarah | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Records: BCH-4940 Eastern Avenue 21224 | |
| 18. 260 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DUE TO Hypertension
(B) DUE TO Hypoglycemia
(C) Diabetes | | INTERVAL BETWEEN ONSET AND DEATH
12 hrs
12 hrs
- | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | ASCD | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 25 19 66 to April 26 19 66, that (I) (we) last saw the deceased alive on April 26 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Richmon | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 4-26-66 | |
| 23C. PHYSICIAN'S NAME (Type) J. Richmon | | 23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4-30-66 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery | |
| 24D. LOCATION Brooklyn, D.C. Co. Ind | | 24E. NAME OF CEMETERY or CREMATORY | | 24F. LOCATION | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 29 1966 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR Charles A. Rice, 661 W. Barre St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>66 04378</u> | |
|---|--------------|--|------------------|--|-----------------------------|--|------------------------------|
| BIRTH NO. <u>66 04378</u> | | | | | | | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>MERCER JAMES A.</u> | | | | 4. 27. 66 <u>11:45</u> <u>A.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| <u>Lutheran Hospital of Maryland</u> | | | | <u>MD</u> | | <u>Harford</u> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | <u>Baltimore</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | <u>3013 Lytleton Rd.</u> | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. |
| <u>male</u> | <u>negro</u> | <u>married</u> | <u>11-30-94</u> | <u>71</u> | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | | <u>North Carolina</u> | | <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Charles Mercer</u> | | | | <u>Elizabeth</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| | | | | <u>Rebecca Mercer 3013 Lytleton Rd.</u> | | | |
| 18. <u>331X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) <u>Subdural hematoma, bilateral</u> | | | |
| | | | | (B) <u>Cortical atrophy</u> | | | |
| ANTECEDENT CAUSES | | | | (C) _____ | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| <u>2</u> | | | | <u>yes</u> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3.23.66</u> 19 to <u>4.27</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4.27.66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) <u>GRUMBERG JOSEF</u> M.D. | | | | 23D. ADDRESS <u>Lutheran Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>5-2-66</u> | | <u>Arbutus Mem. Park</u> | | <u>Arbutus, Balto. Co. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| <u>APR 29 1966</u> | | <u>[Signature]</u> | | <u>Charles A. Rice, 661 W. Baver St</u> | | | |

4/13/64 not covered by water of river below
water on the bank of river below

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|-------------------------------------|--|--|
| W-2561 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 66 04379 | |
| BIRTH NO. 66 04379 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) WAGNER, DOROTHY ROSANNA | | 2. DATE AND HOUR OF DEATH
April 28 '66 8 25 am M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 12-82 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
The Union Memorial Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location)
Hopkins Apts # 507 | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
7/6 / 01 | 9. AGE (In years, last birthday)
64 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
AMERICAN | | 13. FATHER'S NAME
CHARLES H. WAGNER | | | |
| 14. MOTHER'S MAIDEN NAME
LILLIE J.D. BRUNS | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | |
| 16. SOCIAL SECURITY NO.
214-14-1524 | | 17. INFORMANT ADDRESS
MISS LILLIAN C.R. WAGNER (SAME) | | | |
| 18. 330 X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cerebral hemorrhage
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Aneurysm of left posterior Cerebral artery | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
2 hr | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from April 23 19 66 to April 28 19 66 , that (2) (we) last saw the deceased alive on April 28 19 66 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Wen Han Tsung | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
WEN HAN TSUNG | | 23D. ADDRESS
M.D. UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-2-66 | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | | |
| 25B. NAME OF REGISTRAR
R. E. Jenkins | | 25C. FUNERAL DIRECTOR, ADDRESS
H. W. Jenkins & Sons Co. 4905 York Road Balto. Md. 21212 | | | |

The Union Memorial Hospital
Hopkins Astor - 22

James White single
RE TIED
CHARLES H. WAGNER
LILLIE BRUNS
MAYLAD

April 28 1904
X
T. J. ...
12 1/2 ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04380 | |
|---|---------------------|---|--------------------------------------|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO.
M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) FRANCES P. VETRI | | | |
| 2. DATE AND HOUR OF DEATH
4/27/66 12:12 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
MD. General Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)
A. STATE MD.
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
4004 Southern Ave. Nursing Home
D. STREET ADDRESS (If rural, give location)
Baltimore, Md. 21213-01 | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Widow | 8. DATE OF BIRTH
1/27/1885 | 9. AGE (in years last birthday)
81 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
retiree | | 10B. KIND OF BUSINESS OR INDUSTRY
Tailor | | 11. BIRTHPLACE (State or foreign country)
Italy | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
? Stephen Balbo | | | |
| 14. MOTHER'S MAIDEN NAME
? Mary Concetta Santangelo | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
214-12-2134 | | 17. INFORMANT
L. O. Olson, MD. MD. Gen. Hosp | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
420.0 I Pulmonary embolism massive
Arteriosclerotic heart disease | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 4/26 1966 to 4/27 1966 that (I) last saw the deceased alive on 4/27 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Louis O. Olson | | | | 23B. DATE SIGNED
4/27/66 | |
| 23C. PHYSICIAN'S NAME (Type)
Louis O. Olson | | | | 23D. ADDRESS
MD. General Hosp. (Balto Md) | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/2/66 | | 24C. NAME OF CEMETERY or CREMATORY
Holy Redeemer Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | | |
| 25B. NAME OF REGISTRAR
R. E. Taylor | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck Inc. Balto. Md. 21214 | | | |

Master

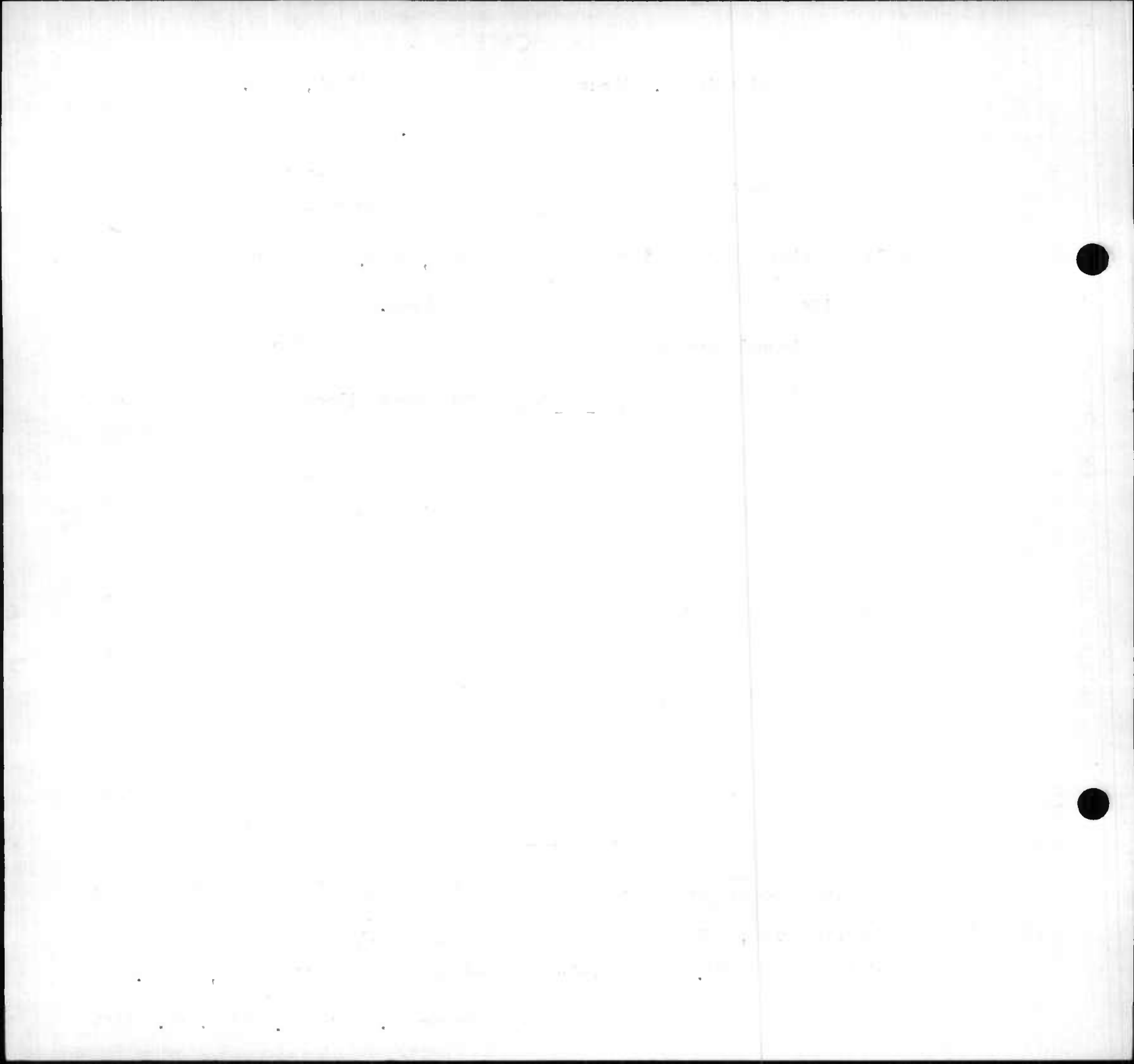
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04381 | |
|---|--|---|--|--|--|
| 66 04381 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | Catherine J. Wilcox | | April 27, 1966. 7:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
4720 York Road | | | A. STATE Md. B. COUNTY 27-11 | | |
| 5. SEX Female | | | 6. RACE White | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow | | | 8. DATE OF BIRTH June 3, 1888. | | |
| 9. AGE (In years last birthday) 77 | | | 10. CITIZEN OF WHAT COUNTRY? USA | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country) Mass. | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Michael Hannaberry | | | 14. MOTHER'S MAIDEN NAME Margaret Sommers | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 164-10-2290 | | |
| 17. INFORMANT Miss Irene Wilcox | | | ADDRESS (Same) | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) Cerebral Thrombosis
(B) Generalized Arteriosclerosis
(C) _____ | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) No | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21D. TIME OF INJURY (APPROX.) | | | 21E. INJURY OCCURRED | | |
| 21F. HOW DID INJURY OCCUR? | | | 21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 22. I certify that (I) (the hospital) attended the deceased from February 1966 to April 27, 1966, that (I) (we) last saw the deceased alive on April 22, 1966, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Stephen Toms, MD | | | 23B. DATE SIGNED
4/28/66 | | |
| 23C. PHYSICIAN'S NAME (Type)
Stephen Toms, MD | | | 23D. ADDRESS
1712 Winford Road | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/30/66. | | 24C. NAME OF CEMETERY OR CREMATORY
Holy Sepulcher Cemetery | |
| 24D. LOCATION
Philadelphia, Penna. | | 24E. NAME OF REGISTRAR
A. D. E. Fisher, M.D. | | 24F. FUNERAL DIRECTOR
Leonard J. Ruck Inc. Balto. Md. 21214 | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |

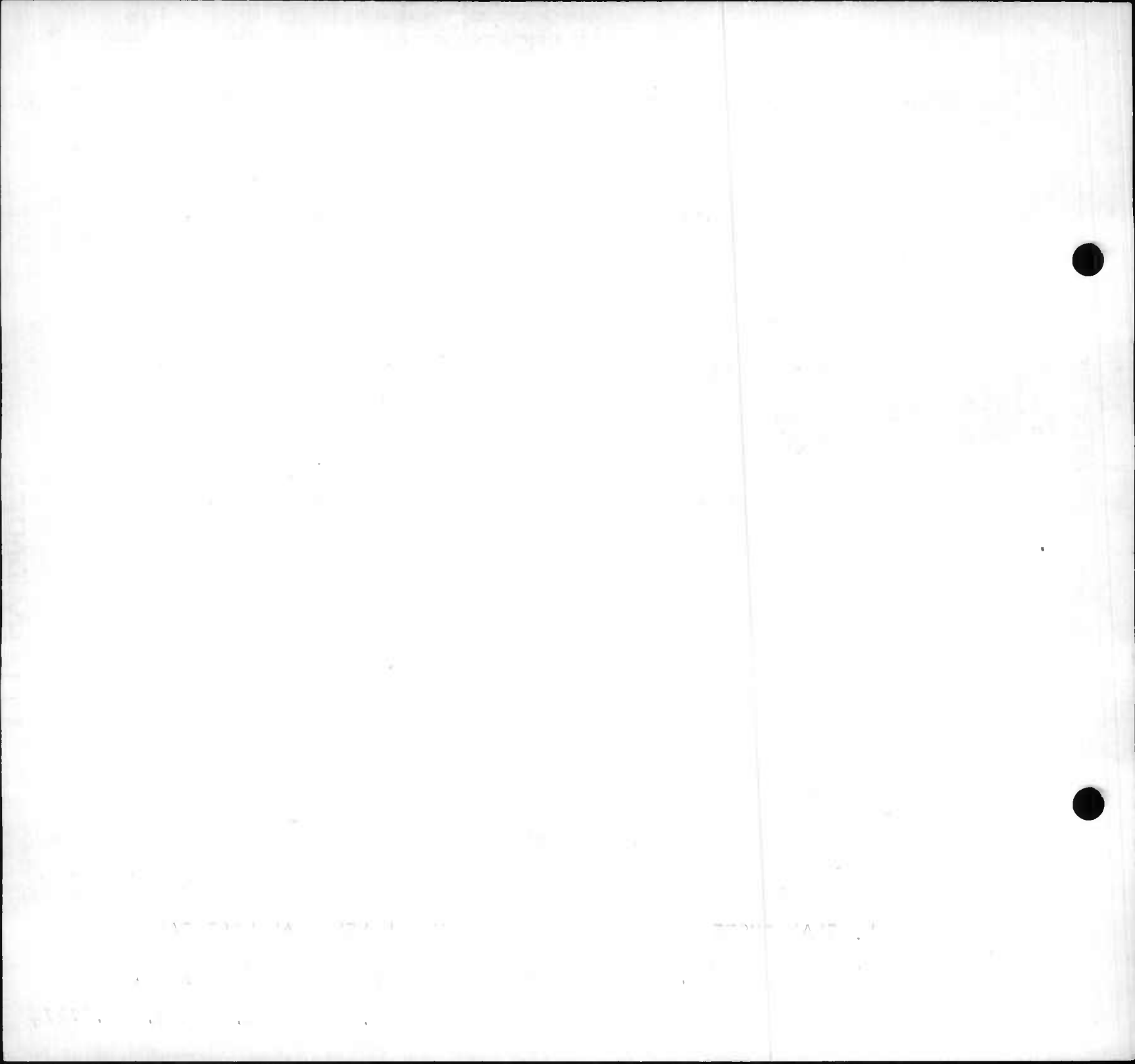


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04382 | |
|--|--|--|---|---|--|
| BIRTH NO. 66 04382 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) STAVROULA GALIXIS | | | 2. DATE AND HOUR OF DEATH
27 APRIL 1966 9:35 P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
UNION MEMORIAL HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY 972 | | |
| 5. SEX F 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | | | 8. DATE OF BIRTH 14 SEPT '93 9. AGE (In years last birthday) 73 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | 11. BIRTHPLACE (State or foreign country) GREECE | | |
| 10B. KIND OF BUSINESS OR INDUSTRY HOME | | | 12. CITIZEN OF WHAT COUNTRY? GREECE | | |
| 13. FATHER'S NAME GEORGE PANOS | | | 14. MOTHER'S MAIDEN NAME STAMATO DEMAKOS | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. UNK. | | |
| 17. INFORMANT HELEN SFONDILIS | | | ADDRESS | | |
| 18. 443 XI
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CEREBRAL HEMORRHAGE
INTERVAL BETWEEN ONSET AND DEATH 2 days | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) Hypertensive ARTERIOSCLEROTIC Heart DISEASE
INTERVAL BETWEEN ONSET AND DEATH 10 years | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 26 April 1966 to 27 April 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 27 April 1966 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. | | | | | |
| 23A. SIGNATURE L. Evan Custer M.D. | | | | 23B. DATE SIGNED 27 April 1966 | |
| 23C. PHYSICIAN'S NAME (Type) L. EVAN CUSTER M.D. | | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4/30/66 | | 24C. NAME OF CEMETERY or CREMATORY Greek Orthodox Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D. BY HEALTH DEPT. APR 29 1966 | | 25B. NAME OF REGISTRAR John E. Bailey | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. ADDRESS 21214 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. | |
|---|---------------|---|------------------------------|---|----------------------------|--|-----------------------------|
| BIRTH NO.
66 04383 | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print)
Edward Harris Lattomus | | 2. DATE AND HOUR OF DEATH
4-26-66 | | 8:20 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
Maryland | | B. COUNTY
9-06 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
Union Memorial Hospital Baltimore Maryland | | C. CITY OR TOWN
(If outside city limits, write RURAL and give township)
Baltimore | | D. STREET ADDRESS
(If rural, give location)
1624 E 30th Street | | | |
| 5. SEX
Male | 6. RACE
W. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
10/19/96 | 9. AGE (In years last birthday)
69 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Delaware | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Joseph Edward Lattomus | | 14. MOTHER'S MAIDEN NAME
Mary Emma Brockson | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
518X I
Empyema Lt. chest | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
1 week | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
4/24/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Empyema Lt. lung | | 20A. AUTOPSY (Yes or No)
2/66 | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/24 1966 to 4/26 1966, that (I) (we) lost saw the deceased alive on 4/26 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Rodney Sel... | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Path. Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/26/66 | | | |
| 23C. PHYSICIAN'S NAME (Type)
RODNEY GETH | | 23D. ADDRESS
Union Memorial Hosp., Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
REMOVAL | | 24B. DATE
APR 29 1966 | | 24C. NAME OF CEMETERY OR CREMATORY
JOHNS HOPKINS MEDICAL SCHOOL | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | 25B. NAME OF REGISTRAR
P. E. E. Taylor | | 25C. FUNERAL DIRECTOR
MORTUARY SERVICE - BCHD | | ADDRESS | |

Expenses of 1st 1/2

1/2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66-04384 | |
|--|--|---|---|---|--|
| BIRTH NO. 66-03741 66 04384 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH
April 16, 1966 2:30 P.M. | | | |
| 1. NAME OF DECEASED
(Type or Print)
Timothy Harris | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital
1514 Division Street
Baltimore, Maryland | | | |
| 5. SEX
Male | | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
2-27-66 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10B. KIND OF BUSINESS OR INDUSTRY
None | | 9. AGE (In years last birthday)
2 | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Maxine Gerse | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
same as above | |
| 18. 491X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause I(A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Bronchopneumonia
(B) _____
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Hypoglycemia | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 16, 1966 to April 16, 1966 , that (I) (we) last saw the deceased alive on April 16, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Linnel C. Rose M.D. | | | | 23B. DATE SIGNED
April 26, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
L.C. Rose | | | | 23D. ADDRESS
1514 Division Street, BALTIMORE, MARYLAND | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
APR 29 1966 | | 24C. NAME OF CEMETERY OR CREMATORY
JOHNS HOPKINS MEDICAL SCHOOL | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | 25B. NAME OF REGISTRAR
R. E. F. J. F. J. F. | | 25C. FUNERAL DIRECTOR ADDRESS
MORTUARY SERVICE - BCHD | |

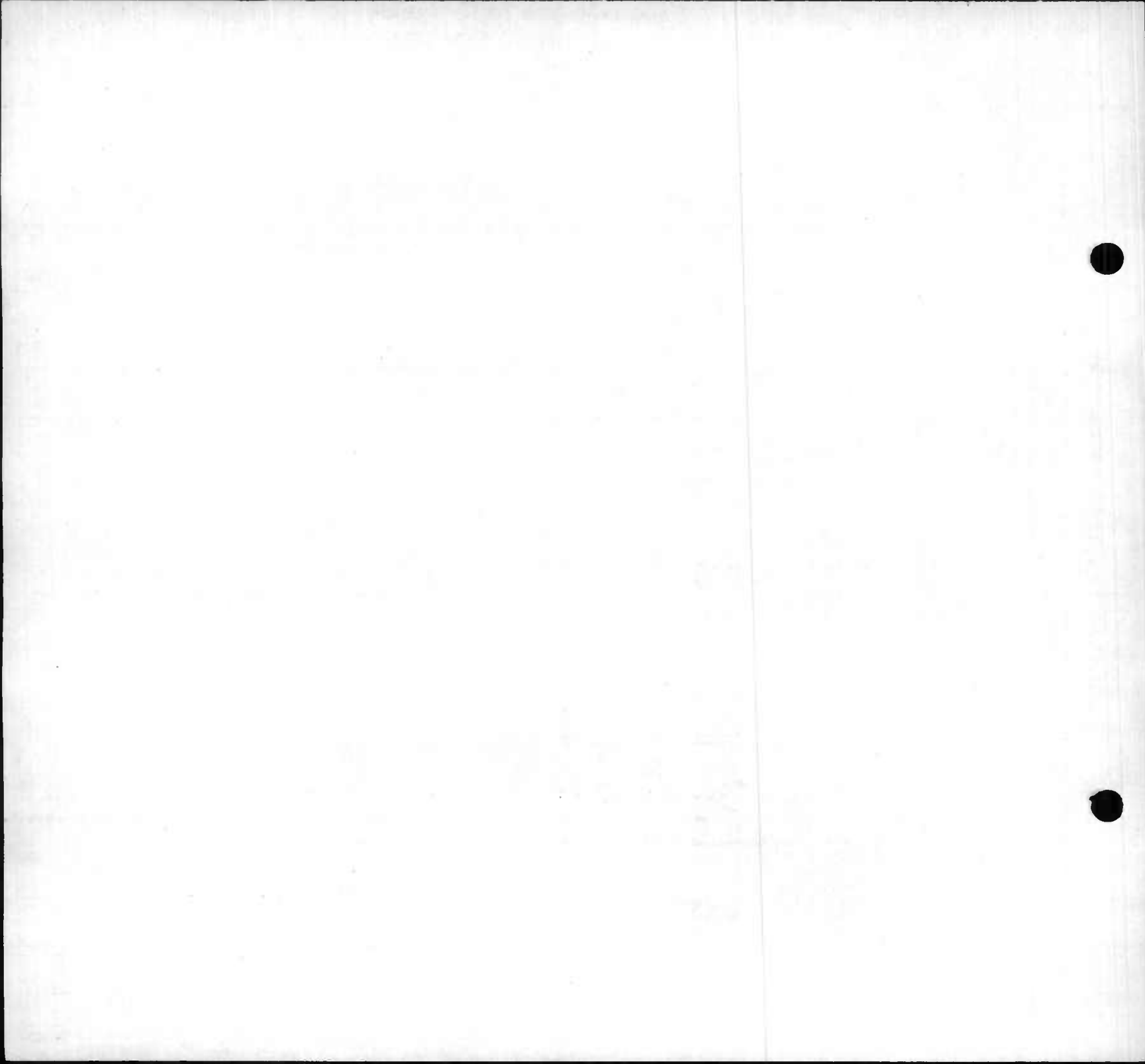
20-75-5

11.000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

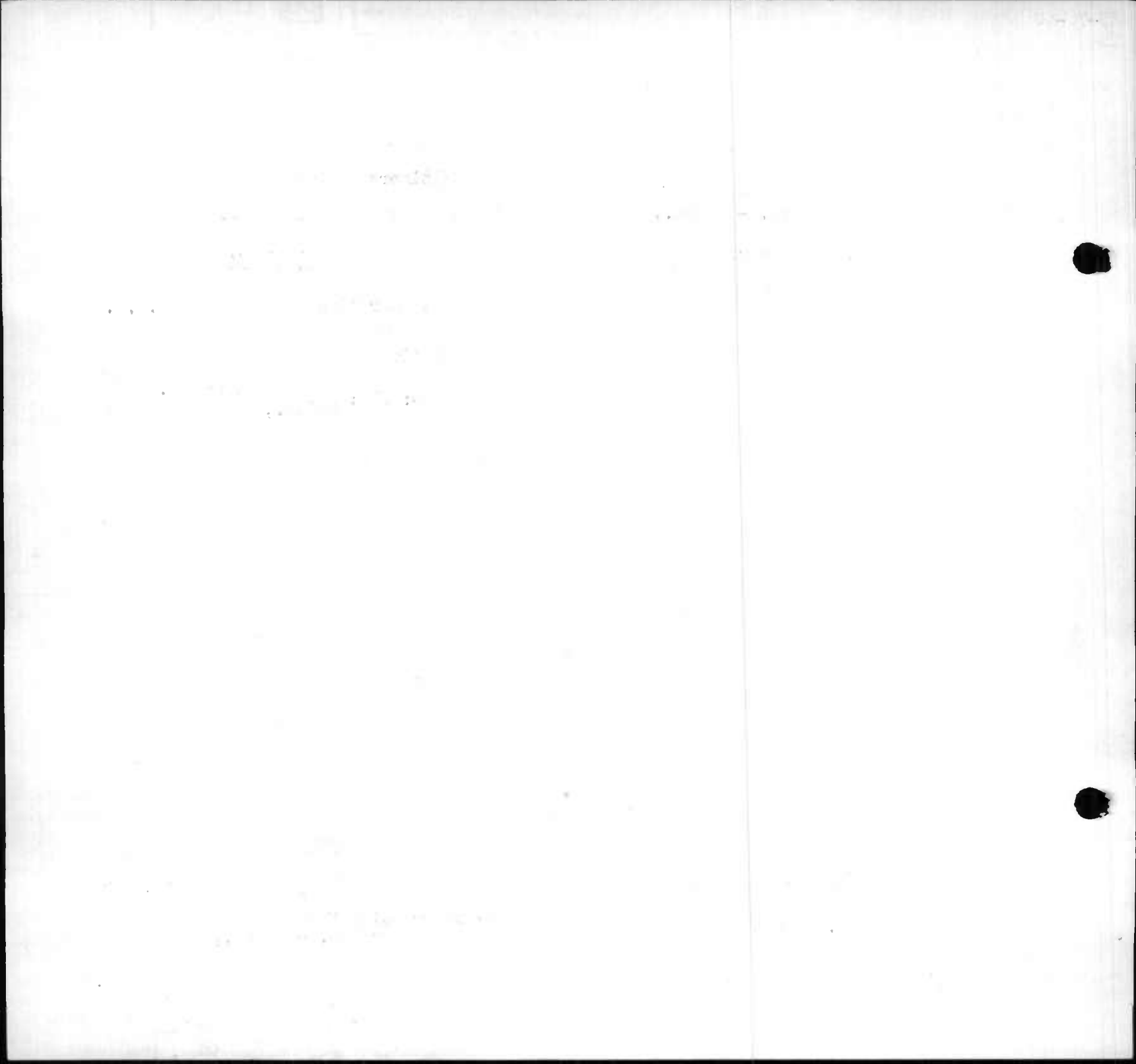
| | | | | | |
|--|-----------|--|------------------------------|--|--|
| BIRTH NO. 66-08564 66 04385 | | BALTIMORE CITY HEALTH DEPT. | | Registered No. 66 04385 | |
| M.E. CASE NO. | | T. NAME OF DECEASED (Type or Print) BABY BLACKSTON | | 2. DATE AND HOUR OF DEATH APRIL 25, 1966 12:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 LUTHERAN HOSP. OF MD. | | A. STATE MARYLAND, U.S.A. | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-38 | | | |
| | | D. STREET ADDRESS (If rural, give location) 3416 MONMOUTH AVE. | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEWBORN | 8. DATE OF BIRTH APRIL 24/66 | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: Hours: Min. 16 15 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME CHARLES BLACKSTON | | 14. MOTHER'S MAIDEN NAME BEVERLY | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) IMMATURITY | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-24-66 19 to 4-25 19 66, that (I) (we) last saw the deceased alive on 4-24 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Marcia Evangelista | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 4/25/66 | |
| 23C. PHYSICIAN'S NAME (Type) MARCIA EVANGELISTA | | 23D. ADDRESS 46 LUTHERAN HOSP. OF MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE APR 29 1966 | | 24C. NAME OF CEMETERY OR CREMATORY JOHNS HOPKINS MEDICAL SCHOOL | |
| | | 24D. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 29 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04386 | |
|---|------------------|---|--|--|---|
| F-462
BIRTH NO. 66 04386 | | CERTIFICATE OF DEATH | | Registered No. 66 04386 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) ELIZABETH FLOWERS | | 2. DATE AND HOUR OF DEATH
4/27/66 1:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
BALT. CITY HOSPITALS
4940 Eastern Ave. - Balto., Maryland 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 16-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 918 North Monroe Street | | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
4-9-12 | 9. AGE (In years last birthday)
HH 54 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Thomas Flowers | | 14. MOTHER'S MAIDEN NAME
Hattie | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
RECORDS: BCH: 4940 Eastern Ave.
Balto., Maryland 21224 | | |
| 18. 600.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DUE TO UREMIA
(B) DUE TO CHRONIC PYELONEPHRITIS
(C) | | INTERVAL BETWEEN ONSET AND DEATH
16 mos | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 4-7-1966 to 4-27-1966, that (I) (we) lost saw the deceased alive on 4-26-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
B. Hughes | | | | 23B. DATE SIGNED
4-27-66 | |
| 23C. PHYSICIAN'S NAME (Type)
B. Hughes | | | | 23D. ADDRESS
Baltimore City Hospitals
4940 Eastern Ave. - Balto., Maryland 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-30-66 | | 24C. NAME OF CEMETERY or CREMATORY
Arbutus | |
| 24D. LOCATION (City, town, or county)
Balto Co., Md. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | | |
| 25B. NAME OF REGISTRAR
R. E. Jackson | | 25C. FUNERAL DIRECTOR
MORTON + Pyett | | | |
| 25D. ADDRESS
1701 LAURENS | | | | | |



FUNERAL DIRECTOR: IMPORTANT

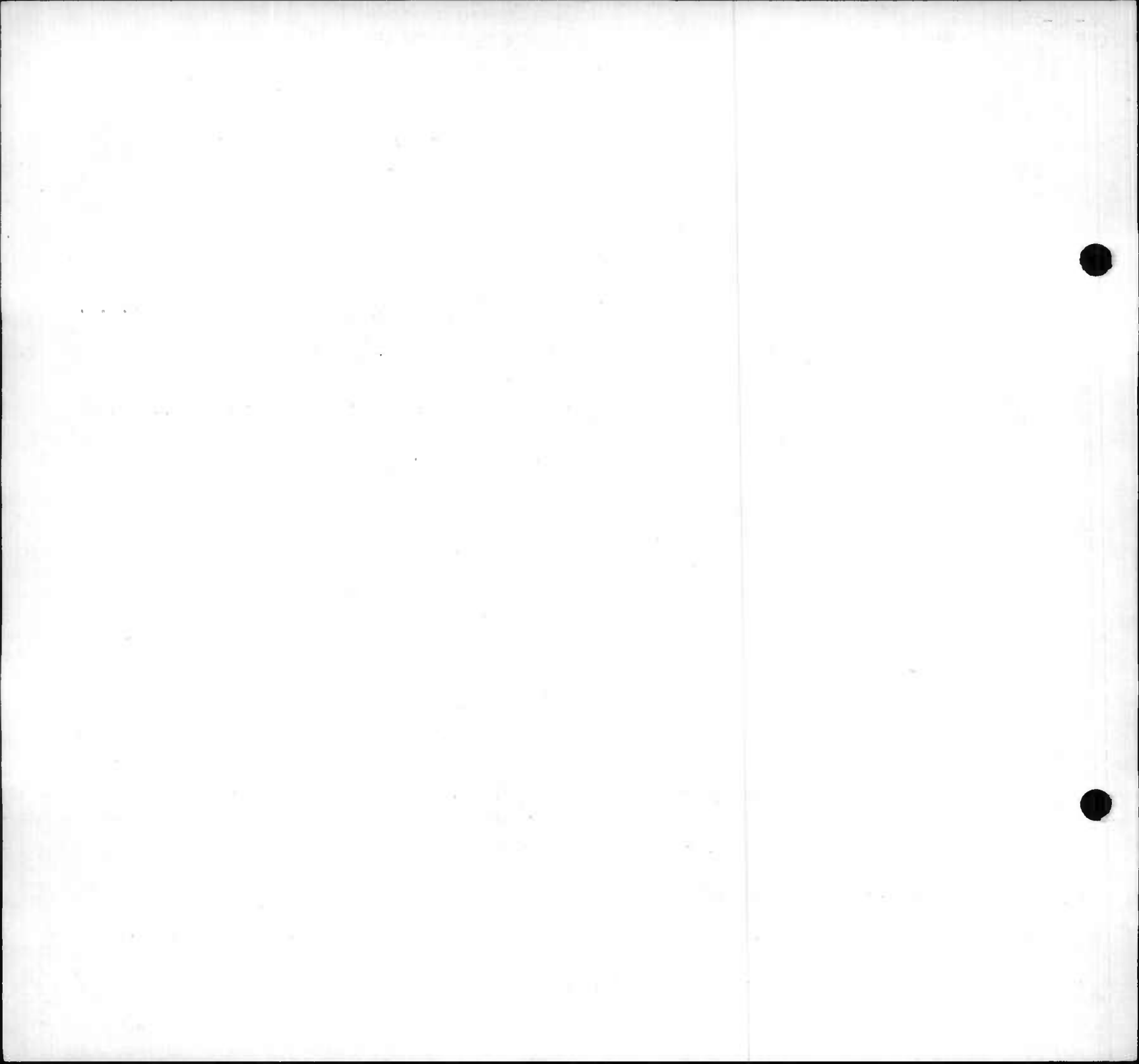
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04387 | |
|--|--|--|--|---|--|
| BIRTH NO. 66 04387 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Estelle Brown (Elizabeth) | | 2. DATE AND HOUR OF DEATH
4/24/66 6:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Md.
B. COUNTY 18-02 | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION
90 Windsor Nursing Home
3025 Windsor Avenue | | 6. DATE OF BIRTH
2-2-1890 | | 7. AGE (In years lost birthday)
75 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
NONE | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
unk | | 14. MOTHER'S MAIDEN NAME
unknown | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
220-01-4683 | | 17. INFORMANT
HOME 3025 WINDSOR AVE
WINDSOR NURSING RECORDS | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH
(A) MYO CARDIAL INFARCTION
(B) Generalized Arteriosclerosis
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MARCH 15 1966 to 4-24 1966 , that (I) (we) last saw the deceased alive on APRIL 24 1966 and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Hollis Seunarine MD</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4-24-66 | |
| 23C. PHYSICIAN'S NAME (Type)
HOLLIS SEUNARINE | | 23D. ADDRESS
M.D. 5519 KENNINSEN AVE BALT MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-27-66 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Calvary | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR ADDRESS
Morton & Dyett Funeral -1701 LAURENS | |

Wm. L. G. Smith
President

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| L-000 | | 66 04388 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04388 | |
|--|-------------------------|---|--|--|--|--|--|
| BIRTH NO. | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) ZULEEN LEE | | | | 2. DATE AND HOUR OF DEATH
APRIL 26, 1966 5:35 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
BALTIMORE CITY HOSPITALS | | (If not in hospital or institution, give street address or location) | | A. STATE
MARYLAND | | B. COUNTY
BALTIMORE | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 28-02 | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
5621 BELLEVILLE AVE | | | |
| 5. SEX
F | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
9-8-39 | 9. AGE (In years last birthday)
26 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Nurse | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Bishopville, S.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Samuel | | | | 14. MOTHER'S MAIDEN NAME
Anna McCaskill | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
219-34-1626 HC | | 17. INFORMANT ADDRESS
RECORDS: BCH, 4940 Eastern Ave., #21224 | | | |
| 18. 203 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
MULTIPLE MYELOMA
CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO
INTERVAL BETWEEN ONSET AND DEATH
11 MONTHS | | | | | | | |
| II
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that 19 (this hospital) attended the deceased from APRIL 4 19 66 to APRIL 26 19 66 , that 19 (we) last saw the deceased alive on APRIL 26 19 66 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
James T. Sparks | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4-26-66 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. JAMES T. SPARKS | | | | 23D. ADDRESS
M.D. 4940 Eastern Avenue, Baltimore, Md., #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4-30-66 | | 24C. NAME OF CEMETERY or CREMATORY
Arbutus Mem. | | 24D. LOCATION (City, town, or county) (State)
Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | 25B. NAME OF REGISTRAR
Robert E. Sparks | | 25C. FUNERAL DIRECTOR
Morton E. Dyett | | ADDRESS
1701 LAURENS | |



FUNERAL DIRECTOR: IMPORTANT

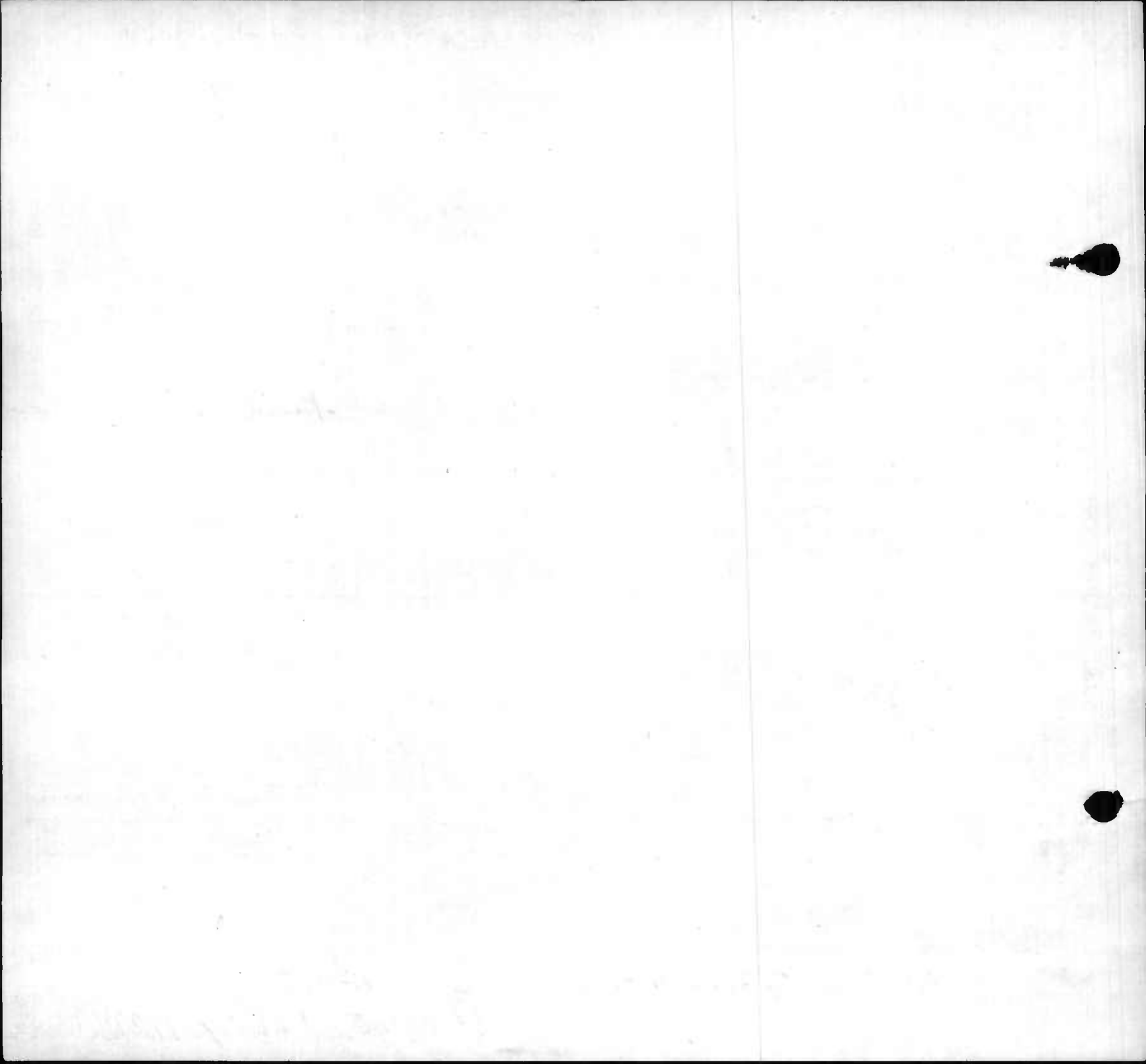
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|---------------------|--|---|---|---|--|---|--|-------------------------------------|--|
| 66 04389
CERTIFICATE OF DEATH | | | | | Registered No. 66 04389 | | | | | |
| BIRTH NO. 66 04389 | | | | | 2. DATE AND HOUR OF DEATH
April 28 th 1966 1:15 a.m. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Doake Welborn</i> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>MD.</i> B. COUNTY <i>1302</i> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>University Hospital</i> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Balto</i> | | | | | |
| D. STREET ADDRESS (If rural, give location)
<i>1908 Park Avenue</i> | | | | | | | | | | |
| 5. SEX
<i>M.</i> | 6. RACE
<i>C</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Married</i> | 8. DATE OF BIRTH
<i>2/11/98</i> | 9. AGE (In years last birthday)
<i>68</i> | If Under 1 Yr. Months: Days: Hours: Min. | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>N.C.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | |
| 13. FATHER'S NAME
<i>Solomon Welborn</i> | | | | | 14. MOTHER'S MAIDEN NAME
<i>Susan Gray</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO.
<i>218-03-7819</i> | | 17. INFORMANT
<i>himself - Berrie Welborn</i> | | | ADDRESS
<i>Same</i> | | |
| 18. <i>1548 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH
(A) <i>Pulmonary edema</i>
DUE TO
(B) <i>Hypostatic pneumonia</i>
DUE TO
(C) <i>Carcinoma of the rectum</i> | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION
<i>April 11 1966</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Hemorrhoids of rectum</i> | | | 20A. AUTOPSY (Yes or No)
<i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4/11</i> 19 <i>66</i> to <i>4/28</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>April 28th</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE
<i>Dr. J. J. J. J. J.</i> M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED
<i>April 28th</i> | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Vigil Thor Thorsteinsson</i> M.D. | | | | | 23D. ADDRESS
<i>Univ. Hospital</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>5/2/66</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Mt. Auburn</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore MD.</i> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>APR 29 1966</i> | | | 25B. NAME OF REGISTRAR
<i>J. J. J. J.</i> | | | 25C. FUNERAL DIRECTOR
<i>Chilington Phillips</i> | | | ADDRESS
<i>1727 N. Mount St.</i> | |



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WARD W WOOD

2. DATE AND HOUR PRONOUNCED DEAD

15 April 1966

8:00 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1823 E. Baltimore St.

5. SEX

male

6. RACE

caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

MAY 30 1913

9. AGE (In years
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during last 12 months. If retired)

STEVEDORE

10B. KIND OF BUSINESS OR INDUSTRY

SHIPPING

11. BIRTHPLACE (State or foreign country)

NORCROSS VA.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

LUTHER WOOD

14. MOTHER'S MAIDEN NAME

BERTHA ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
224-01-9488

17. INFORMANT

ADDRESS

MRS. CLARA M. WOOD 33 S. STRICKER

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Intracerebral Hemorrhage.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles P. Perry

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/16/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

4/29/66

23C. NAME of CEMETERY or CREMATORY

BALTO. NATIONAL

23D. LOCATION

(City, town, or county)

(State)

BALTO. Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 29 1966 R. E. E. Farley

322 S. High
Frank Dilla

VALLER FORGE

MADE IN FRANCE

MADE IN FRANCE

MADE IN FRANCE

MADE IN FRANCE

MADE IN FRANCE

MADE IN FRANCE

MADE IN FRANCE

MADE IN FRANCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Baltimore City Health Department | |
|--|--|--|---|--|--|
| BIRTH NO. | | 66 04391 | | Registered No. 66 04391 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Sarah J. Hawkins | | | 2. DATE AND HOUR OF DEATH
4-26-66 7 50 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1742 Druid Hill Ave. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY | | |
| 5. SEX F | | | 6. RACE Negro | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed |
| 8. DATE OF BIRTH 2-17-66 | | 9. AGE (In years last birthday) 100 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Julian Harris | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Florence Wilson 1742 Druid Hill Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH
(A) Myocardial Insufficiency 2 wks
(B) Senile Arteriosclerosis 12 yrs
(C) Hypertension 12 yrs —
None | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1938 to 4-26-66 that (I) (we) last saw the deceased alive on 4-26-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Geo. H. Pendleton | | | | 23B. DATE SIGNED 4-28-66 | |
| 23C. PHYSICIAN'S NAME (Type) Geo. H. PENDLETON M.D. | | | | 23D. ADDRESS 1723 Druid Hill Ave | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5-1-66 | | 24C. NAME OF CEMETERY OR CREMATORY Cooper Chaple Cemetery | |
| 24D. LOCATION (City, town, or county) Calvert County, Maryland | | 24E. STATE (State) Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 29 1966 | | 25B. NAME OF REGISTRAR Robert E. Farber M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Winkey Sweett Anne Sweett, Md. | |

7-20-58

Proposed by [unclear]
[unclear] [unclear]
[unclear] [unclear]
[unclear] [unclear]
[unclear] [unclear]

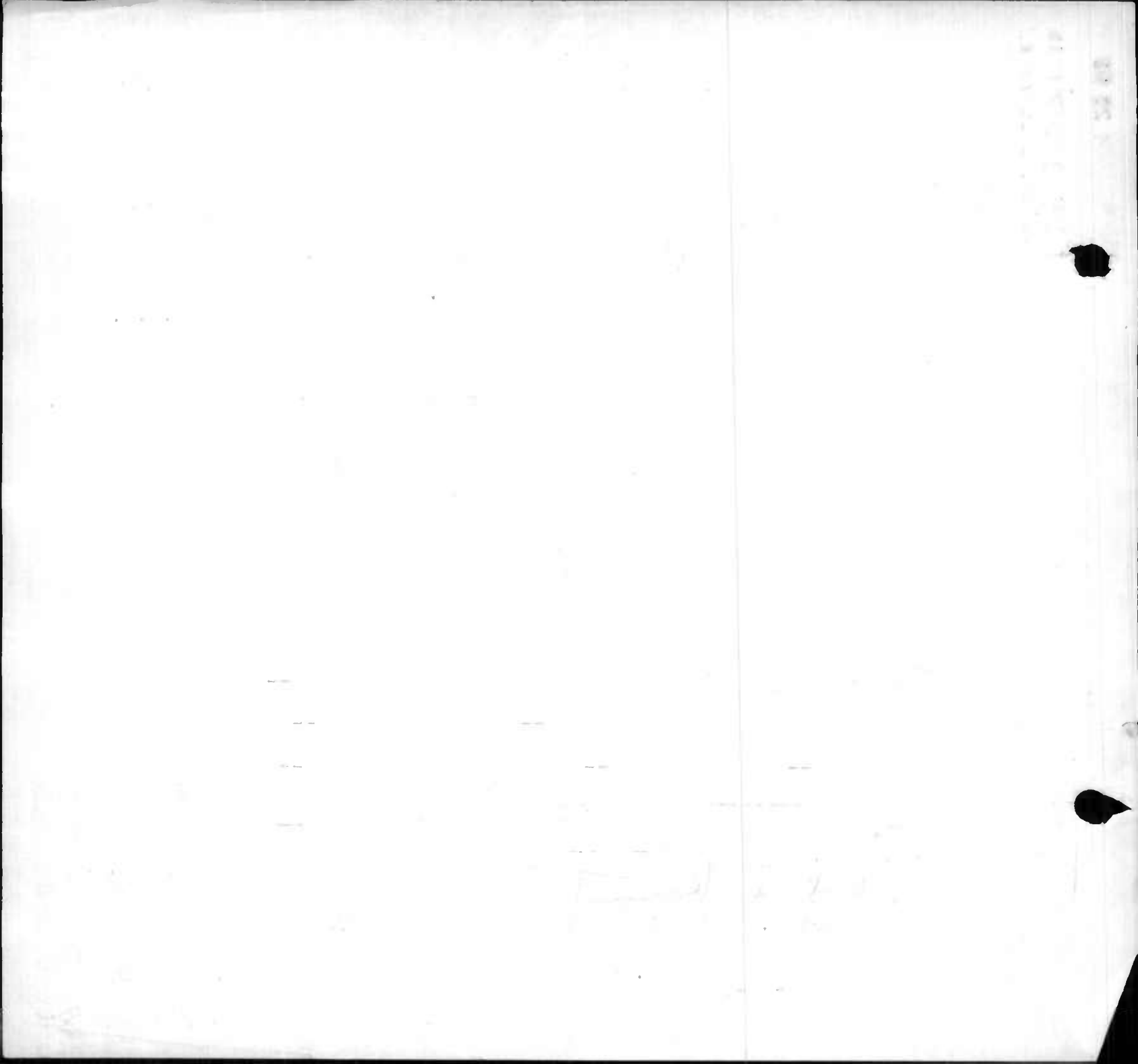
4-26-58 - 38 4-26-58

Geo. H. Pennington 1553 [unclear] Hill [unclear]
[unclear] [unclear] [unclear] [unclear]
4-26-58

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital or the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Underlying disease; (5) A death was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such deceased approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 04392 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REGISTERED NO. 66 04392 | |
|---|------------------|--|-------------------------------|---|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) William A. Alston | | | | 2. DATE AND HOUR OF DEATH
4-26-66 10:55 a.m. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
The Johns Hopkins Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 22216
D. STREET ADDRESS (If rural, give location)
2913 Presstman Street | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widower | 8. DATE OF BIRTH
2-14-1904 | 9. AGE (In years lost birthday)
62 | 10. Under 1 Yr. Months: Days: Hours: Min.
If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Ga. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Ed Alston | | | | 14. MOTHER'S MAIDEN NAME
Betty Simmon | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Herbert Royster | | ADDRESS
2913 Presstman St. | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Metastatic thyroid carcinoma months
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION
0 March 1966 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
thyroid mass | | 20A. AUTOPSY? (Yes or No)
no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
--- | | 21C. WHERE DID INJURY OCCUR?
--- | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
--- | | 21E. INJURY OCCURRED
While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
--- | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/19/66 19 66 4/26 1966, that (I) (we) lost saw the deceased alive on 4/26 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Robert I. Keimowitz | | | | 23B. DATE SIGNED
4/26/66 | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 23C. PHYSICIAN'S NAME (Type)
Robert I. Keimowitz | | | | 23D. ADDRESS
Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-29-66 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
George E. Nelson | | ADDRESS
1346 Calhoun St. | |



BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65-28277MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 04393

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

STEPHEN BROWN

2. DATE AND HOUR PRONOUNCED DEAD

April 26, 1966

11:20 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1442 Montmor Ct.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Mar 1965

9. AGE (In years
last birthday)10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

4

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Baby

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Brown

14. MOTHER'S MAIDEN NAME

Mary Singleton

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

William Brown

ADDRESS

Lansie

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Respiratory infection with bilateral otitis media
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-27-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4-29-66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cmt

23D. LOCATION (City, town, or county)

Brooklyn

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

APR 29 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Clay A. Wilson 1000 Broadway Ave

WALTER J. FORD

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 4394

1. NAME OF DECEASED
(Type or Print)

VONZELLA

FINNEY

2. DATE AND HOUR PRONOUNCED DEAD

April 25, 1966

7:30 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1019 Bennett Place

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

July 10 - 1914

9. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edward Jackson

14. MOTHER'S MAIDEN NAME

Sarah Dumes

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give wpr or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Miriam Cheeks 924 Wilket Court

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Intracerebral Hemorrhage.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/26/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4-28-66

23C. NAME of CEMETERY or CREMATORY

Mt Airy Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

APR 29 1966

24B. NAME OF REGISTRAR

R. E. F. Jones

24C. FUNERAL DIRECTOR

ADDRESS

Choy O Wilson 1001 Brantley Pl

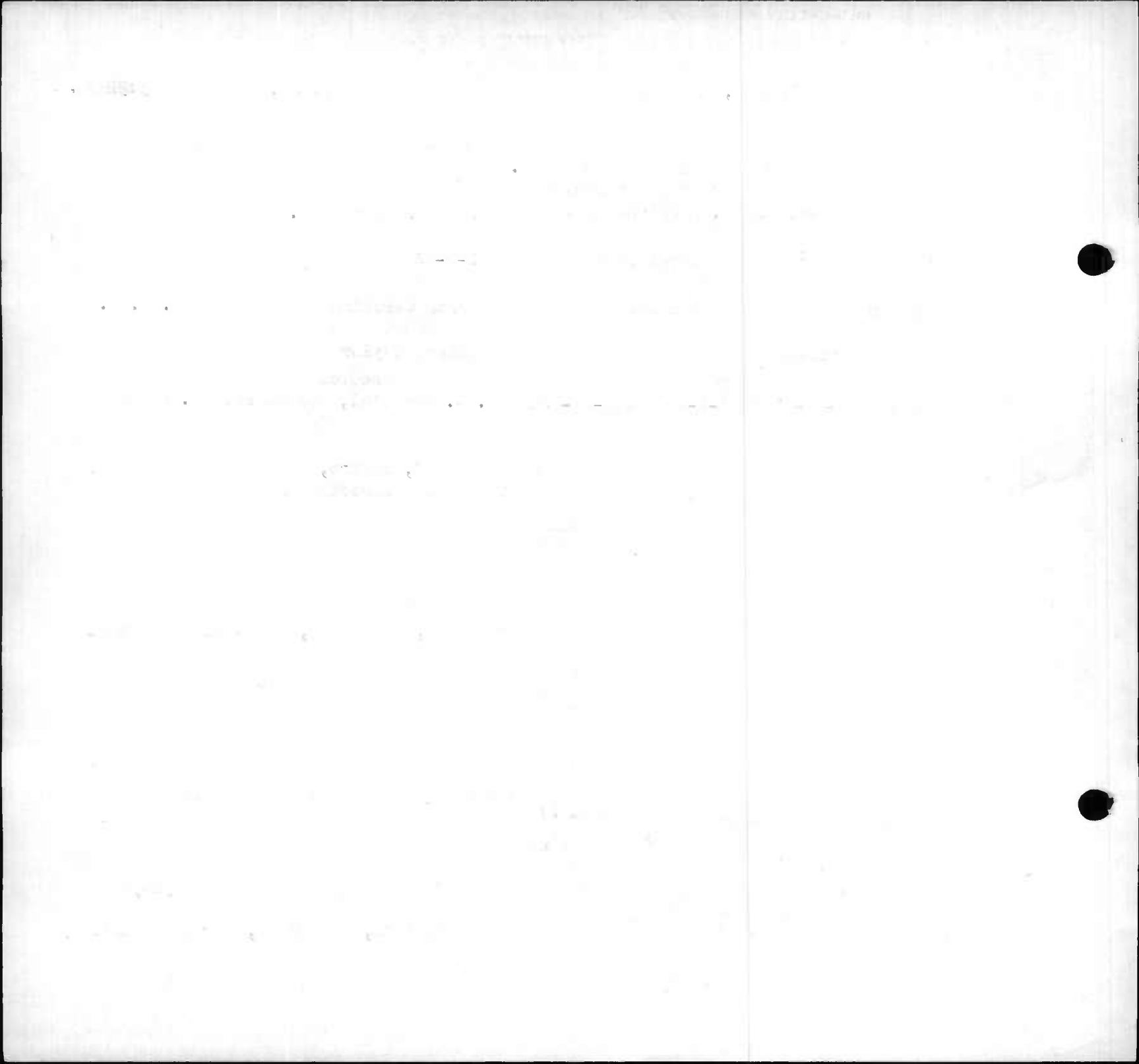
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 04395</u> | |
|---|----------------------------|---|---|--|--|
| BIRTH NO. <u>66 04395</u> | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. <u>66 04395</u> | | | 2. DATE AND HOUR OF DEATH
<u>April 27, 1966</u> <u>3:32 P.</u> M. | | |
| 1. NAME OF DECEASED
(Type or Print) <u>DRUMGOLD, Hammond (NMI)</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Veterans Administration Hosp.</u>
<u>3900 Loch Raven Boulevard</u>
<u>Baltimore, Maryland 21218</u> | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u>
D. STREET ADDRESS (If rural, give location)
<u>1035 McDonough St.</u> | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>Never Married</u> | 8. DATE OF BIRTH
<u>2-2-94</u> | 9. AGE (In years last birthday)
<u>72</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Seaman</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Unknown</u> | 11. BIRTHPLACE (State or foreign country)
<u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> |
| 13. FATHER'S NAME
<u>Henry Drumgold</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Chaney Taylor</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>Yes</u> <u>1-17-18 to 3-1-19</u> | | 16. SOCIAL SECURITY NO.
<u>231-12-4416</u> | 17. INFORMANT <u>Records</u> ADDRESS
<u>V. A. Hospital, Baltimore, Md. 21218</u> | | |
| 18. <u>545X 41002.2</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
<u>Malnutrition, severe, secondary to Total Gastrectomy 1948</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>18 years</u> | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Tuberculosis, Pulmonary, Inactive</u> | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | <u>6 years</u> | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>February 15</u> 19 <u>66</u> to <u>April 27</u> 19 <u>66</u> , that <u>X</u> (we) lost saw the deceased alive on <u>April 27</u> 19 <u>66</u> and that in <u>X</u> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (We) (did) <u>XXXX</u> view the body after death. | | | | | |
| 23A. SIGNATURE

M.D. <u>Mary Lou McIlhany</u> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
<u>4/28/66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>MARY LOU McILHANY</u> | | | | 23D. ADDRESS
M.D. <u>VA Hospital, Baltimore, Maryland 21218</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | 24B. DATE
<u>5-2-66</u> | 24C. NAME OF CEMETERY OR CREMATORY
<u>Balto Nat. Cml</u> | 24D. LOCATION (City, town, or county) (State)
<u>Balto Md</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 29 1966</u> | | 25B. NAME OF REGISTRAR
<u>P. B. E. J. McIlhany</u> | 25C. FUNERAL DIRECTOR ADDRESS
<u>E. Roy O. Wilson 1000 Bristle Bay Ave.</u> | | |



BIRTH NO.

66 04396

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 04396

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PAUL WOODLEY

2. DATE AND HOUR PRONOUNCED DEAD

April 23, 1966

9:45

A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1622 E. Lombard St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1622 E. Lombard St.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widower

8. DATE OF BIRTH

8-10-1909

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Liberal

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph Woodley

14. MOTHER'S MAIDEN NAME

Alice Mosley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

215-09-6419

17. INFORMANT

Albert Woodley, 421 Miller Ave

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-23-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4-28-66

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem

23D. LOCATION (City, town, or county)

Baltimore

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 29 1966

24B. NAME OF REGISTRAR

Robert E. ...

24C. FUNERAL DIRECTOR

Choy Wilson 1001 Beantley Ave

ADDRESS

WALLING
FORDS

8-10-1919
Mr.
Allen Brady
Dept. of Justice
Washington, D.C.

Yours very truly,
J. Edgar Hoover

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 04397 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 04397 | |
|--|-------------------------|---|--|---|--|--|---|---|--|
| 1. NAME OF DECEASED
(Type or Print) Lucy Curry | | | | 2. DATE AND HOUR OF DEATH
April 26, 1966 8:40 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital
1514 Division Street
Baltimore, Maryland | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY 16-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
934 Harlem Avenue | | | | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
2-14-89 | | 9. AGE (In years last birthday)
77 | | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | | 10B. KIND OF BUSINESS OR INDUSTRY
None | | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Ada Green
ADDRESS
934 Harlem Avenue | | | | |
| 18. 420.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Conjunctive heart Failure
DUE TO (A)

ANTECEDENT CAUSES
(B) A.S.H.D.
DUE TO
(C)

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 25, 1966 to April 26, 1966 , that (I) (we) last saw the deceased alive on April 26, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<i>R. Theodore</i> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED
April 26, 1966 | | |
| 23C. PHYSICIAN'S NAME (Type)
Roger Theodore | | | | 23D. ADDRESS
M.D. 1514 Division Street | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-30-66 | | 24C. NAME OF CEMETERY or CREMATORY
Covesville | | 24D. LOCATION (City, town, or county) (State)
Gulfport Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | | | 25B. NAME OF REGISTRAR
E. E. Parker | | 25C. FUNERAL DIRECTOR
Cheryl Wilson 1000 Beauty Ave
ADDRESS | | | |

954 Linton Avenue

1919 Division Street
Baltimore, Maryland

5-14-17

Stable

Female Dog

Married

None

None

Unknown

Unknown

Ada Green

Confidential Agent Baltimore

4-8-17

April 17, 1917

April 17, 1917

April 17, 1917

X

1919 Division Street

Robert Theodore

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

66 04398

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 14398

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Ronnie Cotton

2. DATE AND HOUR PRONOUNCED DEAD

4/28/66 10:50 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

710 Lennox St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

June 6, 1919

9. AGE (In years
last birthday)

46

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Labor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

Joan ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner H. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/28/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5-1-66

23C. NAME OF CEMETERY or CREMATORY

Brother Samos Cemetery

23D. LOCATION

(City, town, or county)

(State)

North Carolina

24A. DATE REC'D BY HEALTH DEPT.

APR 29 1966

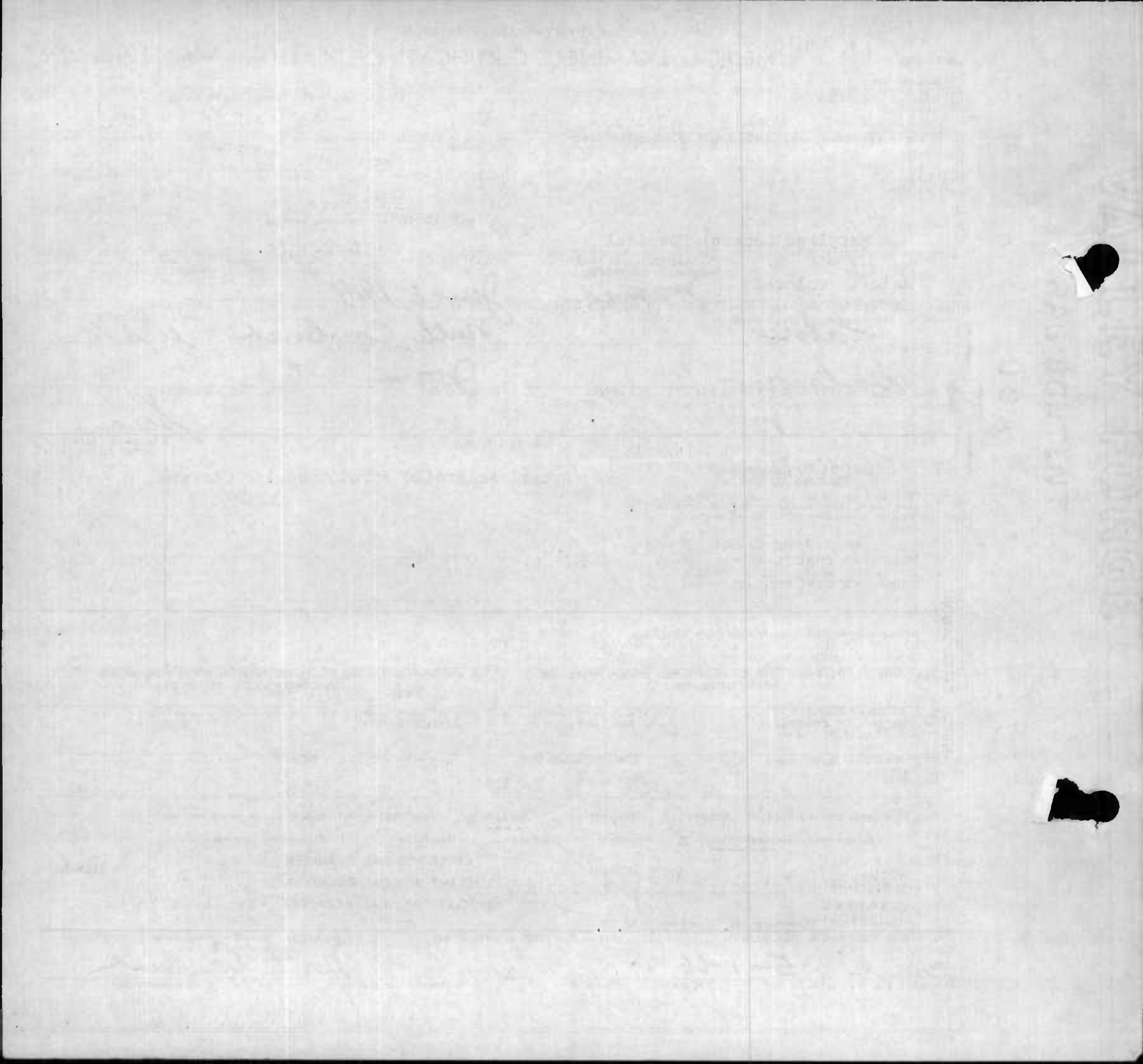
24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Clay O. Wilson 1000 Brantley Ave.



FUNERAL DIRECTOR: IMPORTANT

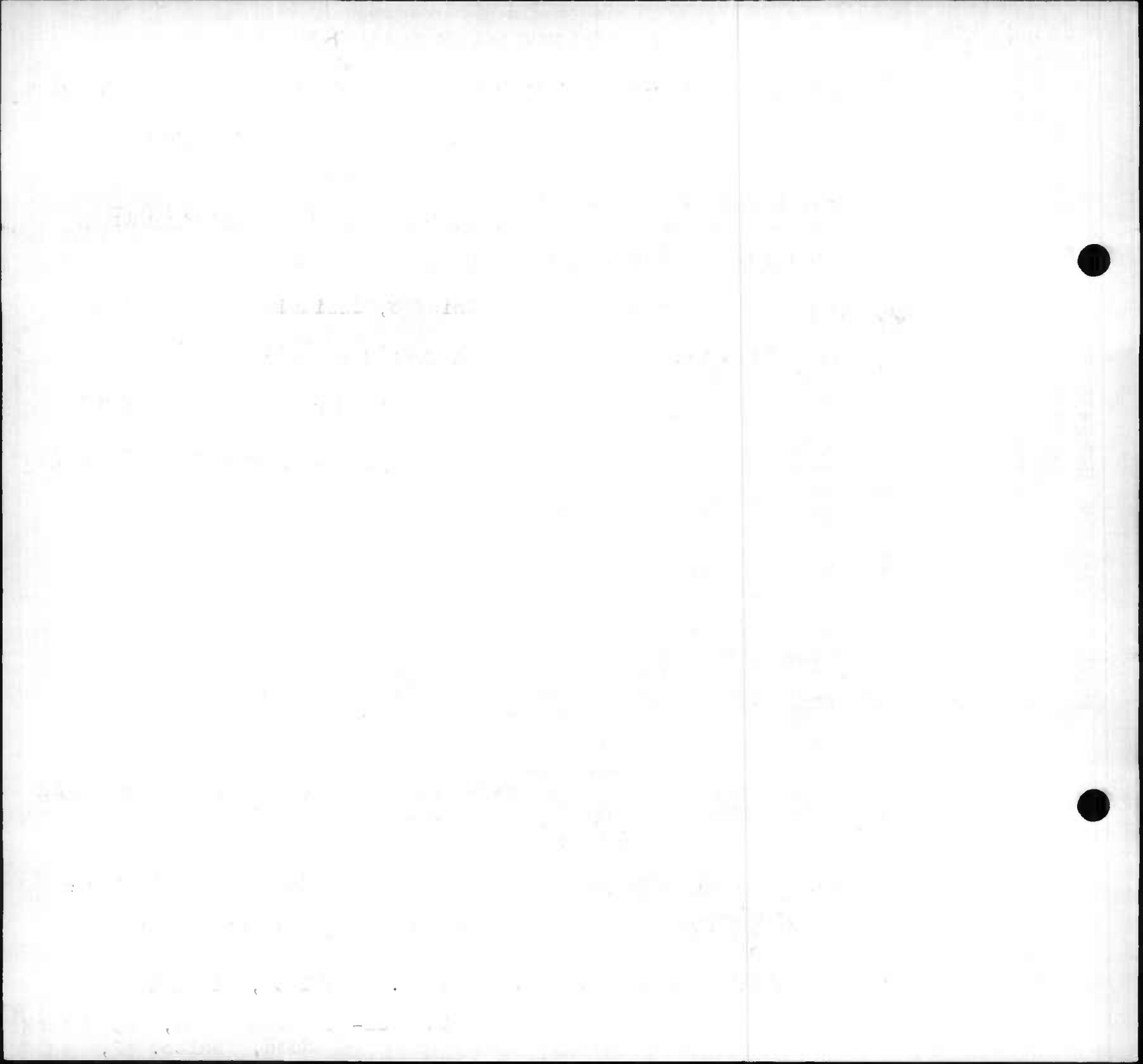
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|------------------|---|-----------------------------|--|---|
| BIRTH NO.
66 04399 | | CERTIFICATE OF DEATH | | 66 04399 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print)
WILLIAM WILHELM | | 2. DATE AND HOUR OF DEATH
4/23/66 11:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Union Memorial Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53700
D. STREET ADDRESS (If rural, give location) 1501 OLD ORENDORF LANE | | | |
| 5. SEX
MALE | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Married | 8. DATE OF BIRTH
6/13/05 | 9. AGE (In years last birthday)
60 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Engineer | | 10B. KIND OF BUSINESS OR INDUSTRY
— | | 11. BIRTHPLACE (State or foreign country)
Chicago, Illinois | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Henry Mueller | | 14. MOTHER'S MAIDEN NAME
Marilyn Steinbohn | |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
— | | 16. SOCIAL SECURITY NO.
— | | 17. INFORMANT
Wife | |
| 18. 15-6.2-1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <u>Myocardial Infarction</u>
(B) <u>—</u>
(C) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH
13 months | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
— | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
— | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
— | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
— | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
— | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb. 25 1966 to April 23 1966, that (I) (we) last saw the deceased alive on April 23 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Walter Thomas Boone | | | | 23B. DATE SIGNED
4/23/66 | |
| 23C. PHYSICIAN'S NAME (Type)
W.T. Boone | | 23D. ADDRESS
Union Memorial Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/26/66 | | 24C. NAME of CEMETERY or CREMATORY
Henderson Methodist Ch. | |
| 24D. LOCATION (City, town, or county) (State)
Hycinth, Virginia | | 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 Robert E. Fisher | | | |
| 25B. NAME OF REGISTRAR
— | | 25C. FUNERAL DIRECTOR
Mitchell-Wiedefeld Home, 6500 York Road, Balto. 12, | | | |

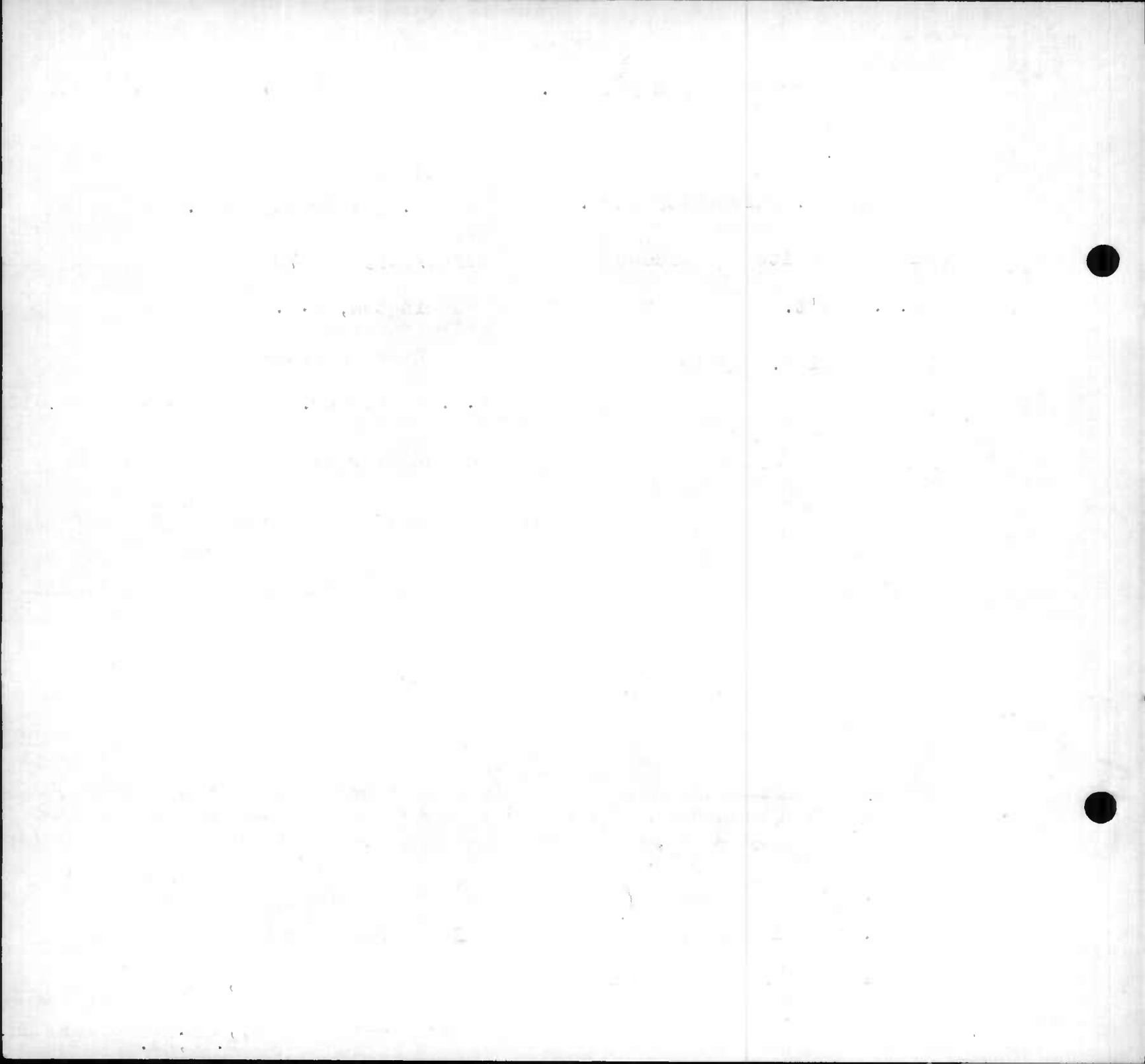


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------|--|--|---|---------------------------------|--|------------------------------|----------------------------------|--|
| 66 04100 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| Registered No. 66 04100 | | | | | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| | | | | Warren Henry Haynie Sr. | | | April 25, 1966 6:00 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE
Maryland | | | | | |
| | | | | B. COUNTY
Baltimore | | | | | |
| 233 E. University Pkwy. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | |
| | | | | Baltimore | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | D. STREET ADDRESS (If rural, give location) | | | | | |
| | | | | 233 E. University Pkwy. | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | |
| male | white | widowed | | 11/21/1895 | 70 | | | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| U.S. Gov't. | | | | Washington, D.C. | | | USA | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Roswell H. Haynie | | | | Anna Rohletter | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| yes | | | | none | | W.H. Haynie Jr. 722 Gladstone Ave. #10 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) Coronary Heart Disease | | | | 3 months | |
| | | | | (B) Atherosclerotic Cardio-Vascular Disease | | | | 2 years | |
| | | | | (C) | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 0 | | | | No | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov 1964 to April 1966, that (I) (we) last saw the deceased alive on April 5 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | |
| Dr. Loy Zimmerman | | | | 4/27/66 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| Dr. Loy Zimmerman | | | | 3202 Harford Road | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) | | (State) | |
| Burial | | 4/28/66 | | Baltimore National | | Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | | | | | |
| APR 29 1966 | | Robert E. Farley | | Mitchell-Wiedefeld Inc. 6500 York Rd. Balto. 12, Md. | | | | | |

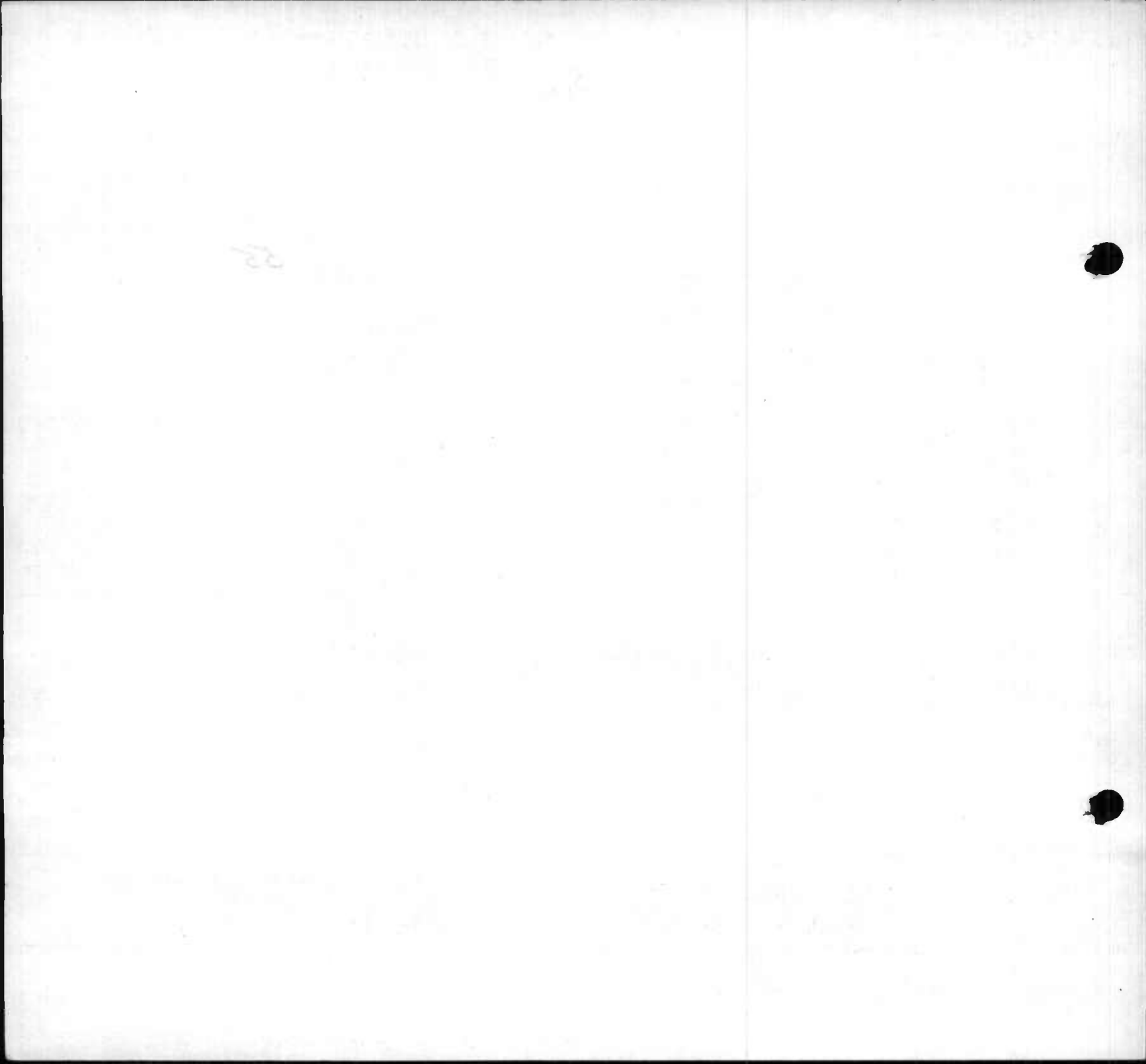


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|---------------------|---|---|---|--|--|---|--|---------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 66 04401 | | | | | |
| BIRTH NO.
66 04401 | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print)
LEVI JAMES CORBIN Jr. | | | | | 2. DATE AND HOUR OF DEATH
4-25-66 10:30 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

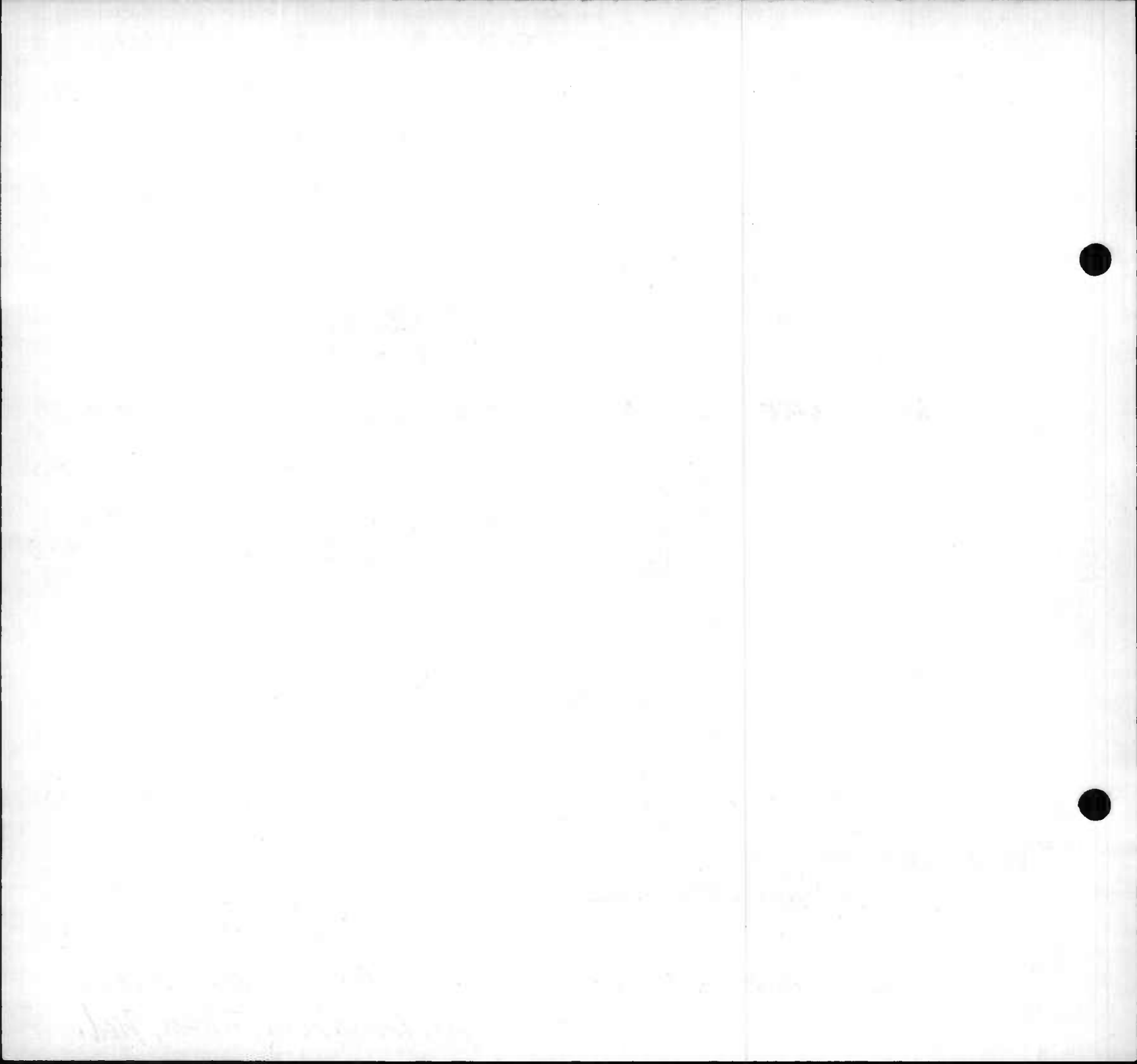
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
UNIVERSITY HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY SANDEWIT
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
WEST OVER, 67-00
D. STREET ADDRESS (If rural, give location)
Rt. #1 Box 62 | | | | | |
| 5. SEX
M | 6. RACE
N | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
8-25-10 | 9. AGE (In years last birthday)
55 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CARPENTER | | | 10B. KIND OF BUSINESS OR INDUSTRY
CARPENTER | | 11. BIRTHPLACE (State or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
LEVI CORBIN | | | | | 14. MOTHER'S MAIDEN NAME
CARRIE DOANE | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO.
- | | 17. INFORMANT ADDRESS
JENESTER CORBIN S/A | | | | | |
| 18. 35-5X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
PULMONARY EMBOLISM
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
CEREBRAL DEGENERATION | | | | | CAUSE OF DEATH
(A) PULMONARY EMBOLISM
DUE TO
(B) CEREBRAL DEGENERATION
DUE TO
(C) FEB. 1966 | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION
3-29-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
HEMIPARESIS - Tumor susp | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
- | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
- | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
- | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR?
- | | | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/8 19 66 to 4/25 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4/25 19 66 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE
Irvin L. Butler | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
4/25/66 | | |
| 23C. PHYSICIAN'S NAME (Type)
IVAN L. BUTLER | | | | | 23D. ADDRESS
University Hosp Balt Md | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/30/66 | | 24C. NAME OF CEMETERY or CREMATORY
OAKVILLE Md near Crisfield | | 24D. LOCATION (City, town, or county) (State)
MD | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | | 25B. NAME OF REGISTRAR
Robert E. Fisher | | | 25C. FUNERAL DIRECTOR
Anthony E. Ware | | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

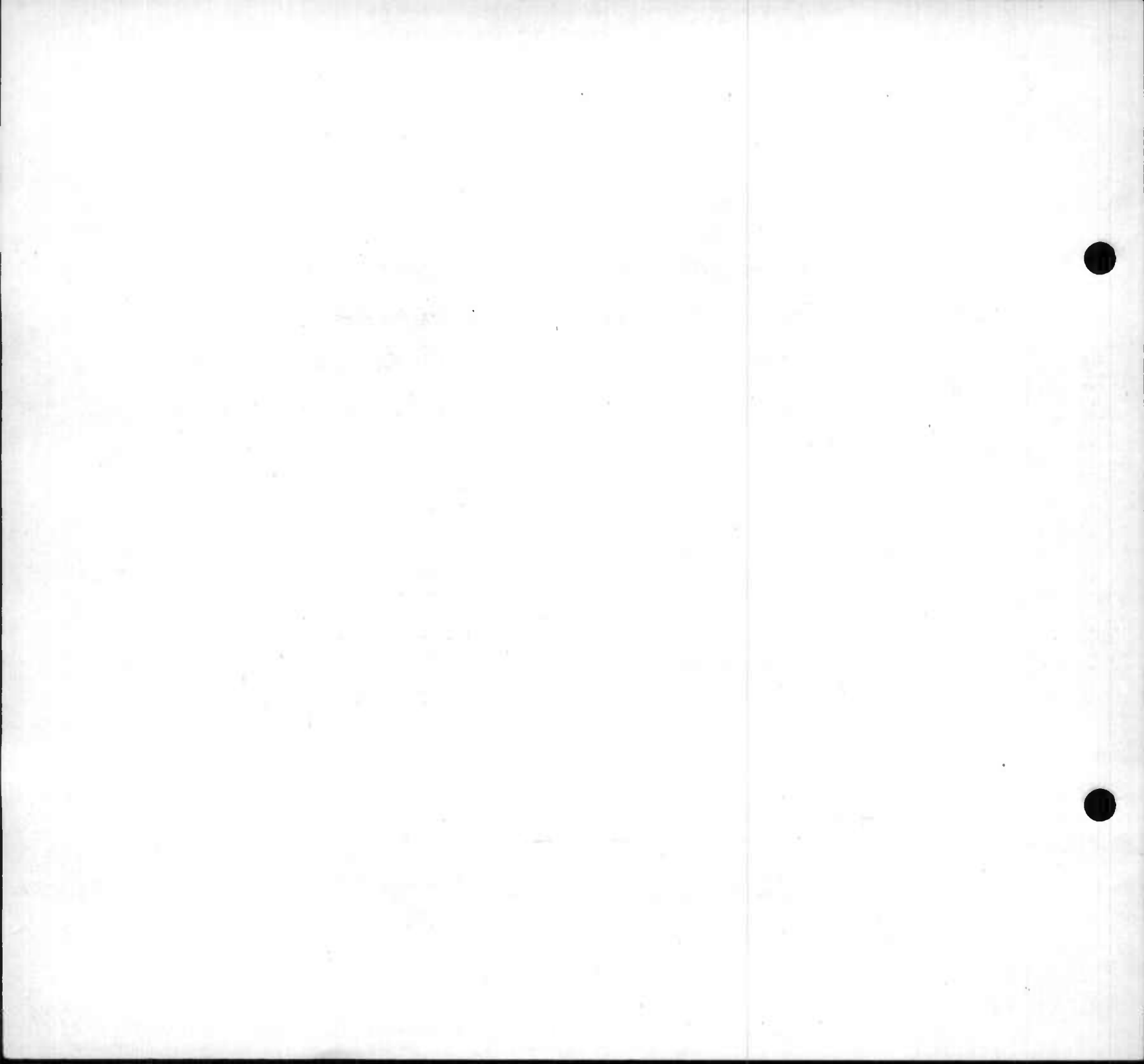
| | | | | | |
|---|--|---|--|---|--|
| BIRTH NO. 66 04402 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04402 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) TRAPP, MR. WILLIAM H. | | 2. DATE AND HOUR OF DEATH 4-26-66 1:20 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 5. AGE (In years lost birthday) 79 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE MARYLAND B. COUNTY Balto | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) COCKEYSVILLE 0300 | |
| D. STREET ADDRESS (If rural, give location) | | 6. DATE OF BIRTH 12-7-1886 | | 7. AGE (In years lost birthday) 79 | |
| 5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 12-7-1886 | | 9. AGE (In years lost birthday) 79 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED (CARPENTER) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALDWIN, MD | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME HENRY TRAPP | | 14. MOTHER'S MAIDEN NAME EMMA BURK | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE | | 16. SOCIAL SECURITY NO. 212-10-9711 | | 17. INFORMANT NANNIE E TRAPP (WIFE) | |
| 18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) TERMINAL PNEUMONIA (B) GENERALIZED ARTERIOSCLEROSIS (C.C.V.A.) (C) | | INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS UNKNOWN (3 YEARS) | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-26-64 to 4-26-66, that (I) (we) last saw the deceased alive on 4-26-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did) (did not) view the body after death. | | 23A. SIGNATURE Zin U. Park | | 23B. DATE SIGNED 4-26-66 | |
| 23C. PHYSICIAN'S NAME (Type) ZIN U. PARK | | 23D. ADDRESS M.D. MONTEBELLO STATE HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE APR. 29, 1966 | | 24C. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY | |
| 24D. LOCATION (City, town, or county) (State) BLENHEIM, BALTO. CO., MD. | | 25A. DATE REC'D BY HEALTH DEPT. APR 29 1966 | | 25B. NAME OF REGISTRAR R. E. FADY | |
| 25C. FUNERAL DIRECTOR John Dunn's Sons, Towson, Md. | | 25D. ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

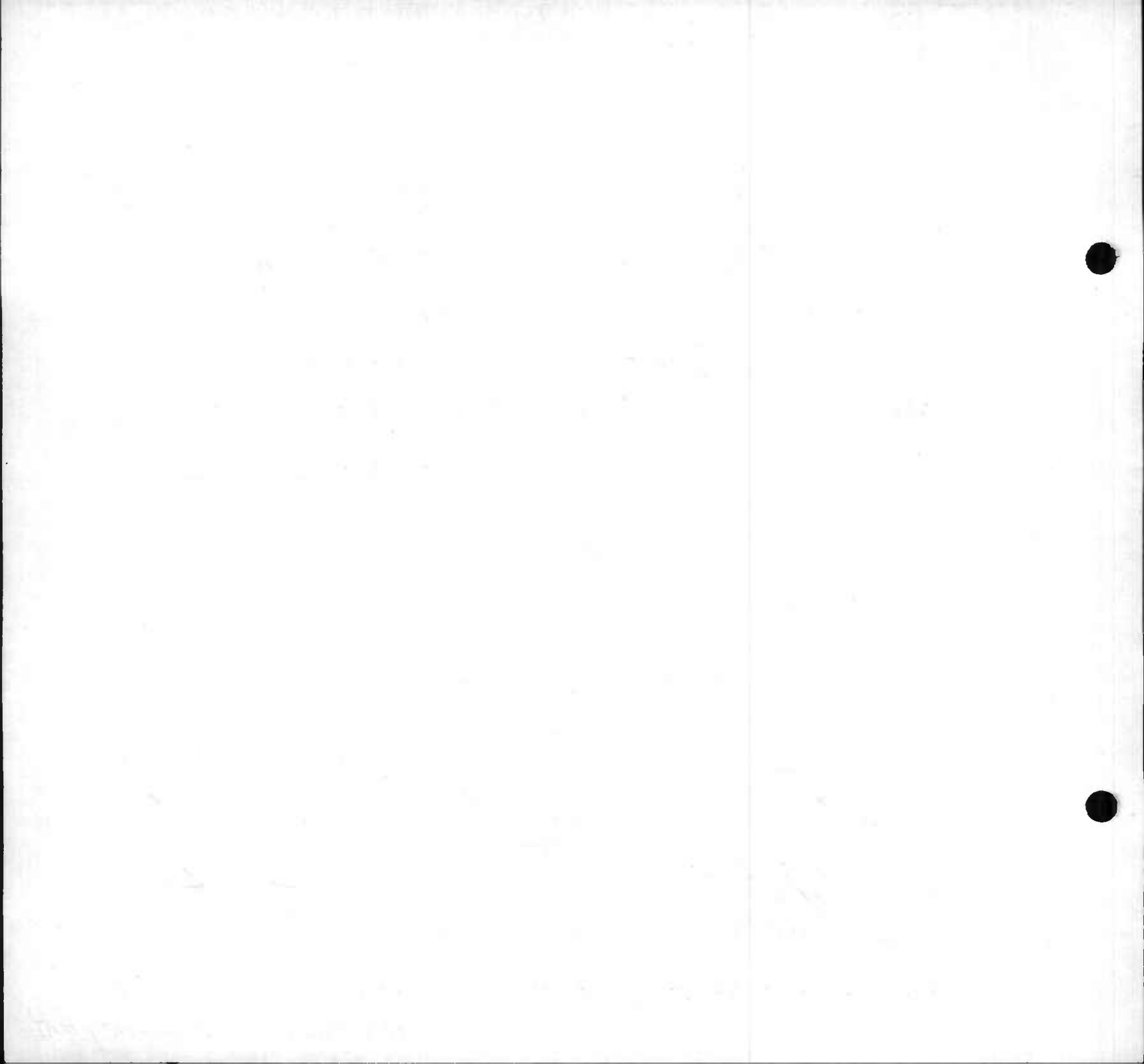
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|--|---|---|--|--|---|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 66 04403 | | | | |
| BIRTH NO. 66 04403 | | | | | M.E. CASE NO. 66 04403 | | | | |
| 1. NAME OF DECEASED
(Type or Print) CHARLES E. ASHLEY SR. | | | | | 2. DATE AND HOUR OF DEATH
4-28-66 M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
4310 MAINE Ave | | | | | A. STATE MARYLAND | | | | |
| | | | | | B. COUNTY 28-02 | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
4310 MAINE Ave | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
BALTIMORE | | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
AUG 23, 1903 | 9. AGE (In years last birthday)
62 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
STAFF ASSISTANT | | | 10B. KIND OF BUSINESS OR INDUSTRY
C & P Telephone Co | | 11. BIRTHPLACE (State or foreign country)
Baltimore | | | 12. CITIZEN OF WHAT COUNTRY?
USA. | |
| 13. FATHER'S NAME
Walter C. Ashley | | | | | 14. MOTHER'S MAIDEN NAME
Ruth Omohundro | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | | 16. SOCIAL SECURITY NO.
212-03-6679 | | 17. INFORMANT
Elsie R Ashley - 4310 MAINE Ave | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
260X I | | | | | CAUSE OF DEATH
Arterio Sclerotic Heart Disease | | | INTERVAL BETWEEN ONSET AND DEATH
2 yrs. | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) DUE TO
Diabetes Mellitus | | | 10 yrs. | |
| | | | | | (B) DUE TO
Chronic Nephritis | | | 2 yrs. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | Old Myocardial Infarction | | | | |
| 19A. DATE OF OPERATION
0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from March 2, 1957 to April 28, 1966 , that (I) was last saw the deceased alive on April 28, 1966 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Earl L. Chambers | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED
4/29/66 | |
| 23C. PHYSICIAN'S NAME (Type)
Earl L. Chambers | | | | | 23D. ADDRESS
4108 Liberty Hts Balto. Md | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5-2-66 | | 24C. NAME OF CEMETERY or CREMATORY
Wood Lawn Cemetery | | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, Md | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | | 25B. NAME OF REGISTRAR
R. E. Fidler | | | 25C. FUNERAL DIRECTOR
ELSWORTH ARMAGOST - 4601 Liberty Hts Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 66 04404 | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| BIRTH NO.
66 04404 | | CERTIFICATE OF DEATH | | | | | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) DeMuth, Pauline | | | | | | 2. DATE AND HOUR OF DEATH
4-29-66 | | 4:15 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
Sinai Hospital | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location)
2171 Coney Ave. #8 | | | | | |
| 5. SEX
Female | | 6. RACE
White | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
6/28/13 | | 9. AGE (In years last birthday)
52 | | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
At Home | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country)
Hungary | | 12. CITIZEN OF WHAT COUNTRY?
Hungary | |
| 13. FATHER'S NAME
Krebsk | | | | | | 14. MOTHER'S MAIDEN NAME
Sourland | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Peter DeMuth - Same | | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
331 XI 260 X | | | | | | CAUSE OF DEATH
Chromic accident | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | | (A) DUE TO | | | | | |
| | | | | | | (B) DUE TO | | | | | |
| | | | | | | (C) DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes mellitus | | | | | | INTERVAL BETWEEN ONSET AND DEATH
? | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (this hospital) attended the deceased from 4/19/66 to 4/29/66, that (I) last saw the deceased alive on 4/28/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Leonard J. Hertzberg, M.D. | | | | | | 23B. DATE SIGNED
4-29-66 | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
Leonard J. Hertzberg - M.D. | | | | | | 23D. ADDRESS
Sinai Hospital Balt. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-2-66 | | 24C. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery - Baltimore, Md | | 24D. LOCATION (City, town, or county) (State) | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 29 1966 | | 25B. NAME OF REGISTRAR
R. J. E. Taylor | | 25C. FUNERAL DIRECTOR
ELSWORTH ARMACOST - 4600 Liberty Hgts | | | | ADDRESS | | | |

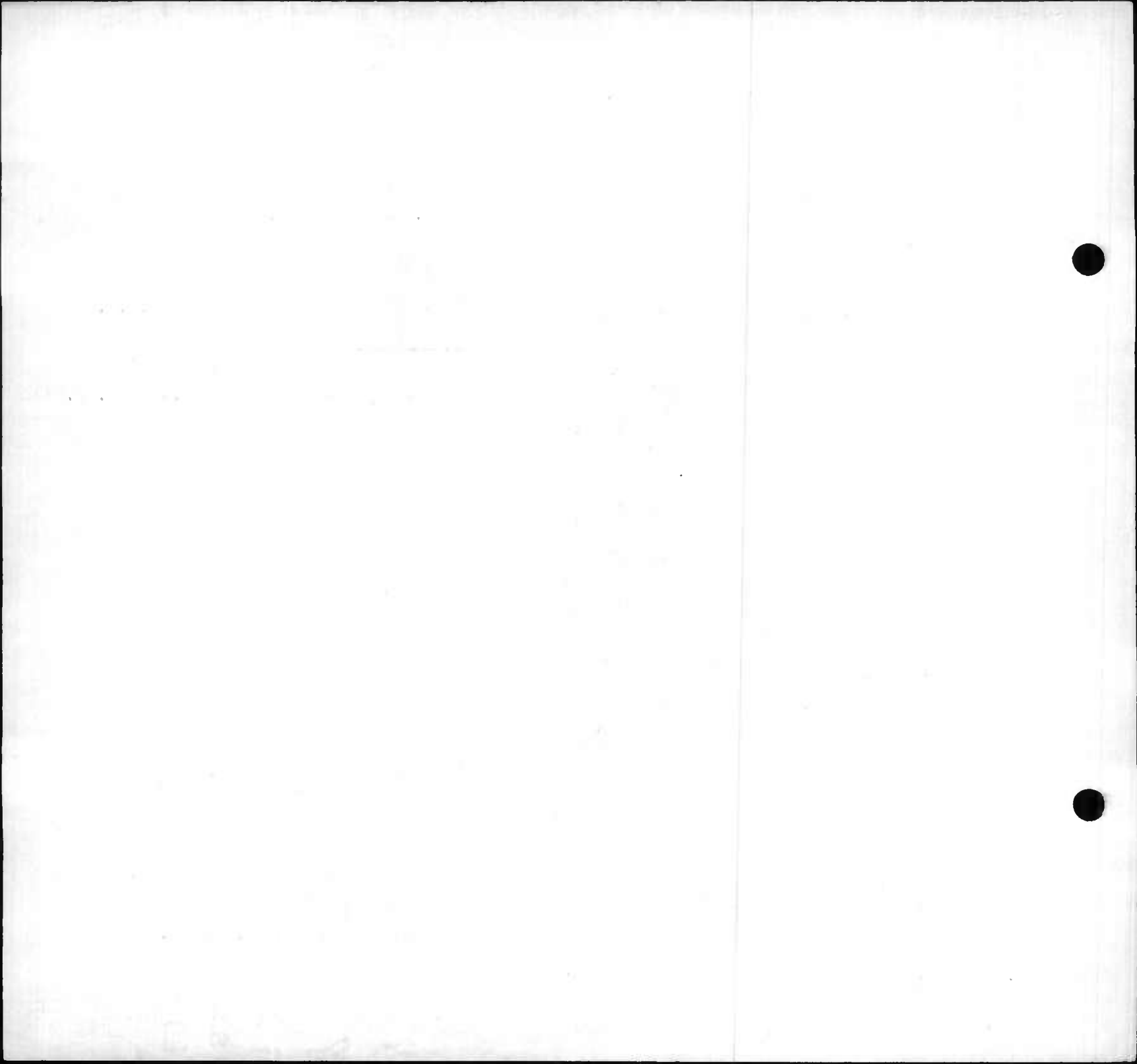


46-15-82
NIW
C-460

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|-------------------------------------|---|---|
| BIRTH NO. 66 04405 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04405 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) CLEARY, MARY C | | 2. DATE AND HOUR OF DEATH
4-28-66 3⁰⁰ A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 7-03 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE MARYLAND 21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| D. STREET ADDRESS (If rural, give location)
528 N. MONTFORD AVENUE 21205 | | | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
12/25/91 | 9. AGE (In years last birthday)
74 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CHARWOMAN | | 10B. KIND OF BUSINESS OR INDUSTRY
J.H.H. | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
ARTHUR HAGAN | | | |
| 14. MOTHER'S MAIDEN NAME
HANNA Mc GHEE | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
RECORDS: BCH 4940 Eastern Ave., Balto, Md. 21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Myocardial Infarction | | CAUSE OF DEATH
Myocardial Infarction | | INTERVAL BETWEEN ONSET AND DEATH
3 mos | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, which led to the above cause (A) stating the UNDERLYING CONDITION last.
ASCVD | | INTERVAL BETWEEN ONSET AND DEATH
2 mos | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
FL hip | | INTERVAL BETWEEN ONSET AND DEATH
4 mos | | | |
| 19A. DATE OF OPERATION
4-26-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Myocardial Infarction - debridement | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home - bedroom | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
528 N. Montford Ave. | |
| 21D. TIME OF INJURY (APPROX.)
12-22-65 6 AM | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
fell off floor | |
| 22. I certify that (1) (this hospital) attended the deceased from 3-14 19 66 to 4-28 19 66 , that (1) (we) lost saw the deceased alive on 4-27 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Alexander Silverman | | | | 23B. DATE SIGNED
4-28-66 | |
| 23C. PHYSICIAN'S NAME (Type)
ALEXANDER SILVERMAN | | | | 23D. ADDRESS
BALTIMORE CITY HOSPITALS
4940 Eastern Avenue, Balto, Md. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5-2-66 | | 24C. NAME OF CEMETERY or CREMATORY
NEW CATHEDRAL CEM. | |
| 24D. LOCATION (City, town, or county) (State)
BALTO., MD. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | 25B. NAME OF REGISTRAR
Robert E. Feltman | | 25C. FUNERAL DIRECTOR ADDRESS
Stanley Miller - 2334 Jefferson St. | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04406

BIRTH NO. 66 04406

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANNA

ZOLENAS

2. DATE AND HOUR PRONOUNCED DEAD

April 30, 1966

5:15 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

405 S. Furrow Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

405 S. Furrow Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

Oct. 25, 1898

9. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

TAILOR

10B. KIND OF BUSINESS OR INDUSTRY

Clothing Mfg.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

CASHMAN ZOLENAS

14. MOTHER'S MAIDEN NAME

Anna Kroukaite

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

NONE

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

Nicodemus Chesno 872 W. Lombard St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
5/1/6623A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR ADDRESS

Burial

5-4-66

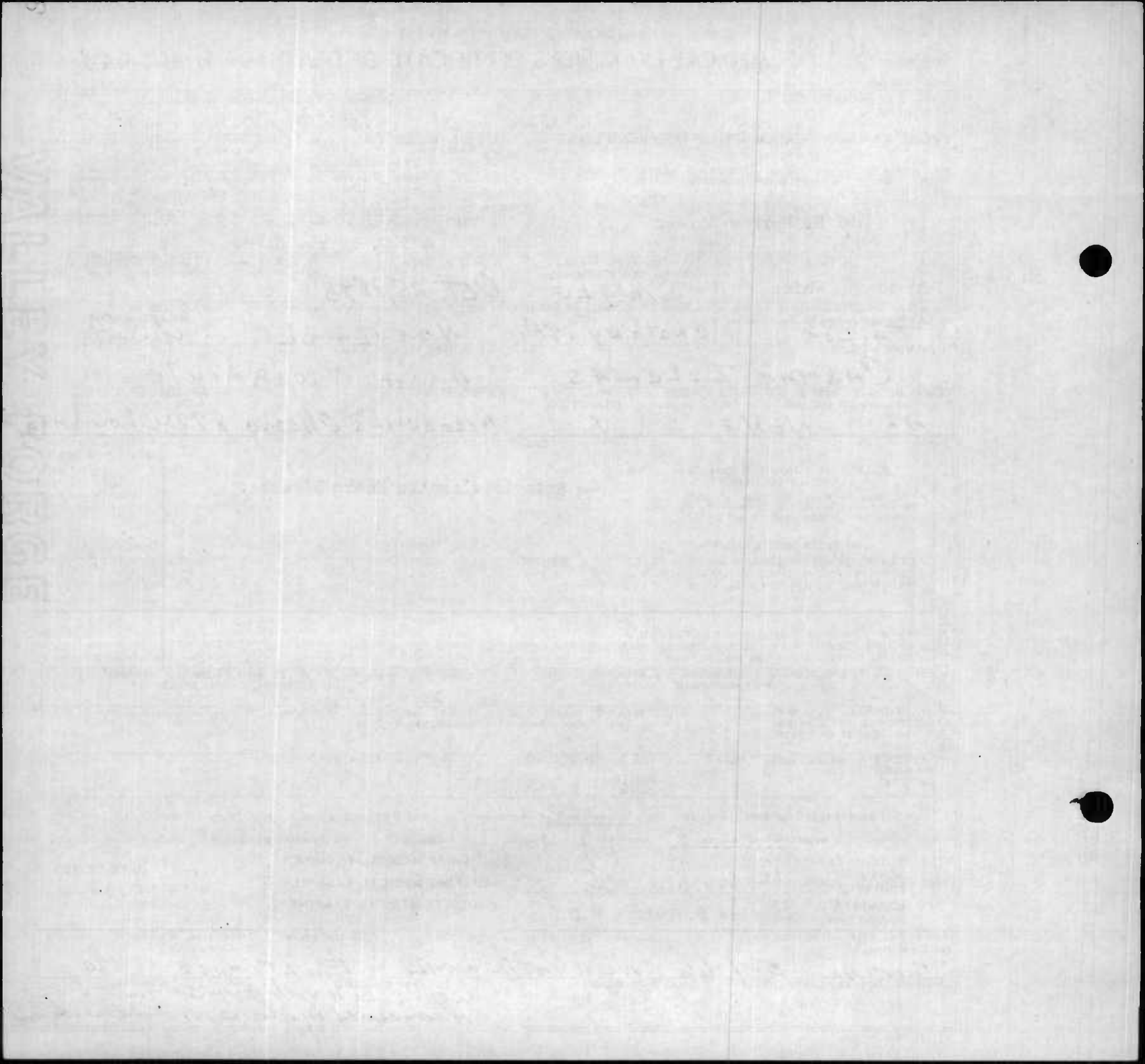
New Cathedral

Baltimore, Md.

MAY 2 1966

P. E. Taylor, M.D.

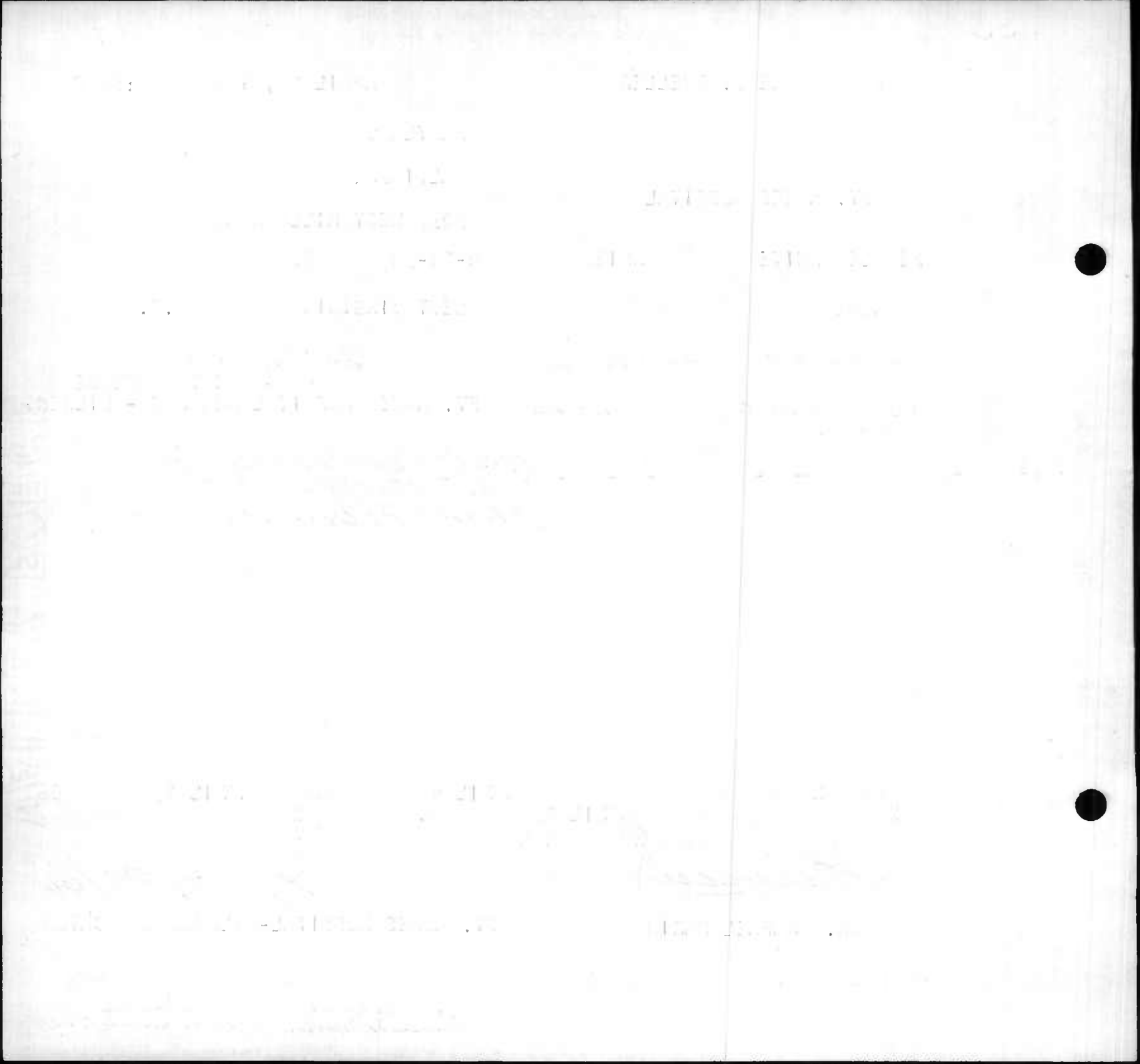
Geo. L. Schomburg Funeral Home
Francis H. Miller 2101 Redwood Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04407 | |
|--|----------------------------|---|------------------------------------|---|---|
| BIRTH NO. 66 04407 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) JANE S. ZOELLER | | 2. DATE AND HOUR OF DEATH
APRIL 29, 1966 8:30 P | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 28-04 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
ST. AGNES HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location)
5037 WEST HILLS ROAD | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
4-24-96 | 9. AGE (In years last birthday)
70 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | 10B. KIND OF BUSINESS OR INDUSTRY
— | | 11. BIRTHPLACE (State or foreign country)
WEST VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. | | 13. FATHER'S NAME
WILLIAM HARRELL | | 14. MOTHER'S MAIDEN NAME
Un Known. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
AND CATON AVENUE ST. AGNES HOSPITAL RECORDS - WILKENS | |
| 18. 738.11
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
Acute Cerebral vascular accident - Atrial Fibrillation. | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| | | (C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 5 1966 to APRIL 29 1966 , that (X) (we) last saw the deceased alive on APRIL 29 1966 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Rafael Marin</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/29/66 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. RAFAEL MARIN | | 23D. ADDRESS
M.D. ST. AGNES HOSPITAL-WILKENS AND CATON | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | 24B. DATE
5-3-66 | 24C. NAME of CEMETERY or CREMATORY
MEADOWRIDGE | | 24D. LOCATION (City, town, or county) (State)
Howard County Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR
GEORGE L. SCHWAB
<i>Funeral Home 2101 Redbank Ave.</i> | |



On approval by Dr Smith Med. Exam.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 04408 | | | | CITY HEALTH DEPARTMENT | | Registered No. 66 04408 | |
|--|-------------------------|--|------------------------------------|--|----------------------------|--|-----------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Cannon, Milton Byron</i> | | | | 2. DATE AND HOUR OF DEATH
<i>4/30/66 3:15 P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>North Charles General Hosp.</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY <i>11</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore 2122 52-00</i>
D. STREET ADDRESS (If rural, give location)
<i>708 Holly Ave.</i> | | | |
| 5. SEX
<i>Male</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>widowed</i> | 8. DATE OF BIRTH
<i>6/14/83</i> | 9. AGE (In years last birthday)
<i>82 yrs.</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>ELECTRIC CO.</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>Unknown</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Unknown</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>21-05-6447</i> | | 17. INFORMANT
<i>Irene Childress 708 Holly Ave.</i> | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<i>Heber pneumonia & abscess of right lung</i>
ANTECEDENT CAUSES
<i>ASCV D. -</i> | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>Malnutrition -</i> | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<i>Recent fracture of T12-L2</i> | | | | | | | |
| 19A. DATE OF OPERATION
<i>4-22-66</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<i>Home</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
<i>708 Holly Ave.</i> | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)
<i>4-28-66 3:30 PM</i> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<i>Slipped while getting out of bed</i> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4/29/66 12:45 PM</i> to <i>4/30/66 3:15 PM</i> and that (I) (we) last saw the deceased alive on <i>4/30/66 3:00 AM</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Shirley M. Swager</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>4/30/66</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>M. Dabolins. M.D. -</i> | | | | 23D. ADDRESS
M.D. <i>400 Crain Highway Balto. Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 24B. DATE
<i>5-3-66</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>NEW CATHEDRAL</i> | | 24D. LOCATION (City, town, or county) (State)
<i>BALTIMORE, Md</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>MAY 2 1966</i> | | 25B. NAME OF REGISTRAR
<i>R. E. Taylor</i> | | 25C. FUNERAL DIRECTOR
<i>George L. Schwab FUNERAL HOME</i>
<i>Francis H. Miller 2101 Ludwig Ave.</i> | | | |

Water Pumping Station

of the pump

Plant location of TIS-12

1/2

Water

Water

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 6632469-97 | |
|---|-----------------------------|--|---|---|---|---|--|
| BIRTH NO.
66 04409 | | | | | | | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Twigg, Lorimer J. | | | | April 26, 1966 4:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
University Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MARYLAND
B. COUNTY ALLEGANY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) LA VALE
D. STREET ADDRESS (If rural, give location) Box 44 LA VALE | | | |
| 5. SEX
MALE | 6. RACE
CAUCASIAN | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
2/10/22 | 9. AGE (In years
last birthday)
44 | 10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)
Self employed | | |
| 10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)
Self employed | | | 10B. KIND OF BUSINESS OR INDUSTRY
Oil Heating | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF
WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
John Twigg | | | | 14. MOTHER'S MAIDEN NAME
Millicent Kallmyer | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
unknown | | | | 16. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT
ADDRESS
ADMISSION RECORD | |
| 18. 5-22-01
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)
Antecedent Causes
DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.
Severe massive regional enteritis 5 deep post op | | | | CAUSE OF DEATH
(A) Primary Main Pulmonary Artery unknown.
Embolic
(B)
(C)
INTERVAL BETWEEN
ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION
4/22/66 | | | | 19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED
Regional Enteritis | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)
none | | | | 21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)
none | | 21C. WHERE DID
INJURY OCCUR?
(If in Baltimore City, give exact location)
none | |
| 21D. TIME
OF INJURY
(APPROX.)
none | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> none While
At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
none | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/3/66 19 66 to 4/26 19 66 ,
that (I) (we) last saw the deceased alive on 4/26 19 66 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Fred R. Eilber | | | | M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/26/66 | |
| 23C. PHYSICIAN'S
NAME (Type)
FRED R. EILBER | | | | 23D. ADDRESS
University Hospital - Baltimore | | | |
| 24A. BURIAL CREMATION,
REMOVAL (Specify)
BURIAL | | 24B. DATE
4/29/66 | | 24C. NAME OF CEMETERY OR CREMATORY
Hill Crest, Baltimore | | 24D. LOCATION
(City, town, or county) Cumberland MD | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | 25B. NAME OF REGISTRAR
R. J. E. Eilber | | 25C. FUNERAL DIRECTOR
Sydney Keshel | | ADDRESS
Cumberland MD | |

1945-1946

10/15/45

MARYLAND

WILLIAM T. KILLAM

ADMISSION RECORD

~~WILLIAM T. KILLAM~~
FEDERAL BUREAU OF INVESTIGATION

WILLIAM T. KILLAM

self employed Oil Heating

2000 Third

unknown

WILLIAM T. KILLAM

10/15/45

WILLIAM T. KILLAM

WILLIAM T. KILLAM

WILLIAM T. KILLAM

WILLIAM T. KILLAM

WILLIAM T. KILLAM

WILLIAM T. KILLAM

WILLIAM T. KILLAM

10/15/45

WILLIAM T. KILLAM

WILLIAM T. KILLAM

WILLIAM T. KILLAM

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|------------------|---|-------------------------------------|
| BIRTH NO.
66 04410 | | CITY HEALTH DEPARTMENT
REGISTERED No. 66 04410 | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH
April 28, 1966 | |
| 1. NAME OF DECEASED
(Type or Print)
JOHN JOSEPH SCHWARZ | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md. 8. COUNTY 12-06 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Home: 2900 Wyman Parkway | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore City | |
| D. STREET ADDRESS (If rural, give location)
2900 Wyman Parkway | | 9. AGE (In years last birthday) 66 | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 10. AGE (In years last birthday) 66 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Owner - | | 10B. KIND OF BUSINESS OR INDUSTRY
Antique Dealer | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Henry Schwarz (Germany) | | 14. MOTHER'S MAIDEN NAME
Mary Jane Donnelly (USA) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
218-32-0643 | |
| 17. INFORMANT
Son | | ADDRESS
Pk, Md. | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Myocardial infarction
H A S H D | | INTERVAL BETWEEN ONSET AND DEATH
Minutes
Years | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 years ago, that (I) (we) last saw the deceased alive on 3-4-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Richard K Gundry | | 23B. DATE SIGNED
4-28-66 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Richard K. Gundry | | 23D. ADDRESS
2 West University Parkway, Balto. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/2/66 | |
| 24C. NAME OF CEMETERY or CREMATORY
St. Peter's Cemetery | | 24D. LOCATION (City, town, or county) (State)
Queenstown, Queen Annes Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | 25B. NAME OF REGISTRAR
R. E. F. F. F. | |
| 25C. FUNERAL DIRECTOR
Stewart & Mowen Co., 108 W. North Av., City. | | ADDRESS | |

Myocardial infarction
H A S H D

NO

1962

1962

1962

Dr. H. H. H. H.

Richard K. H. H.

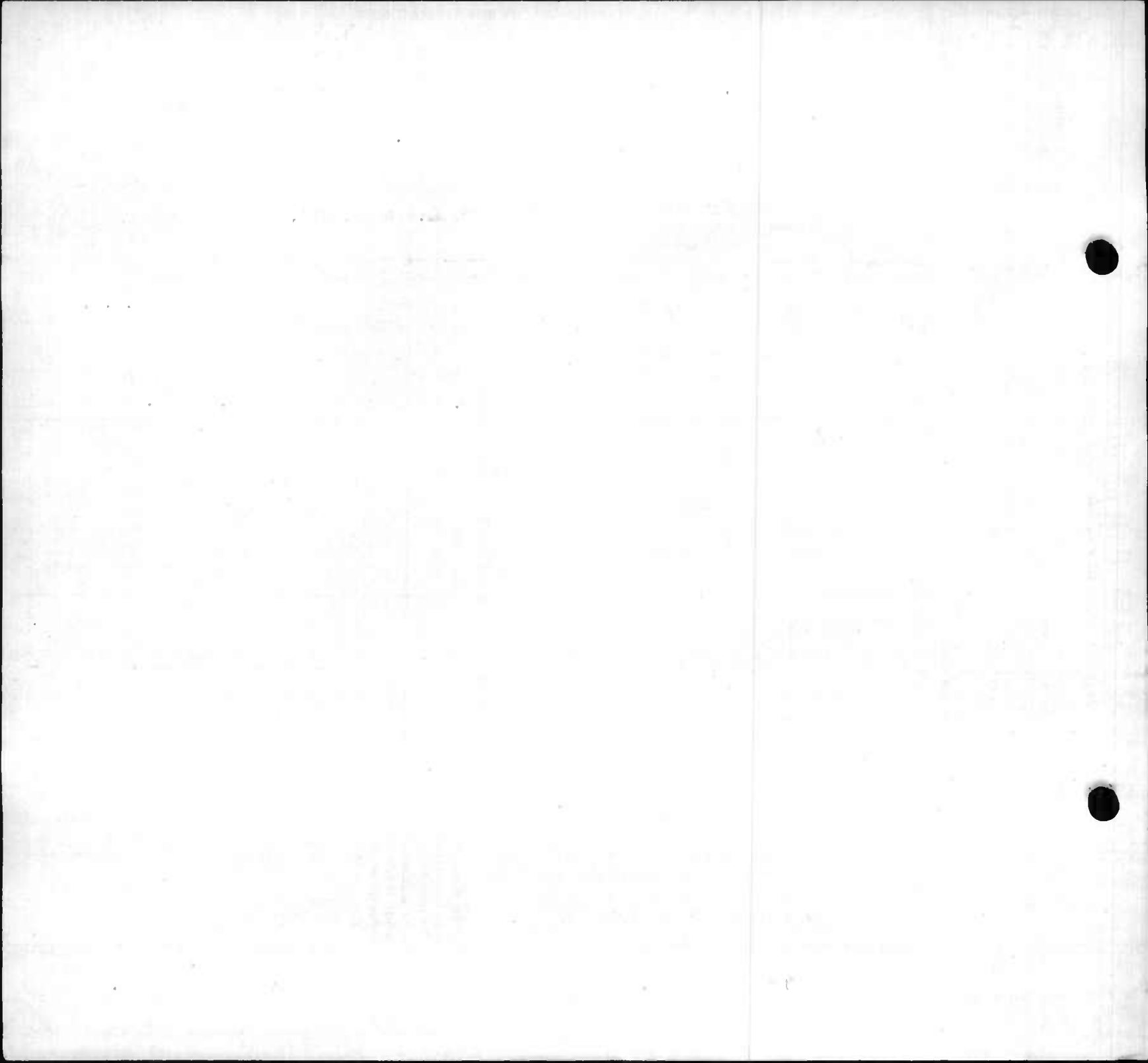
4-28-62

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 04411 | |
|--|------------------|---|--|---|---|--|--|
| BIRTH NO.
66 04411 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print)
Lena O. Pettersen | | 2. DATE AND HOUR OF DEATH
4-24-1966 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

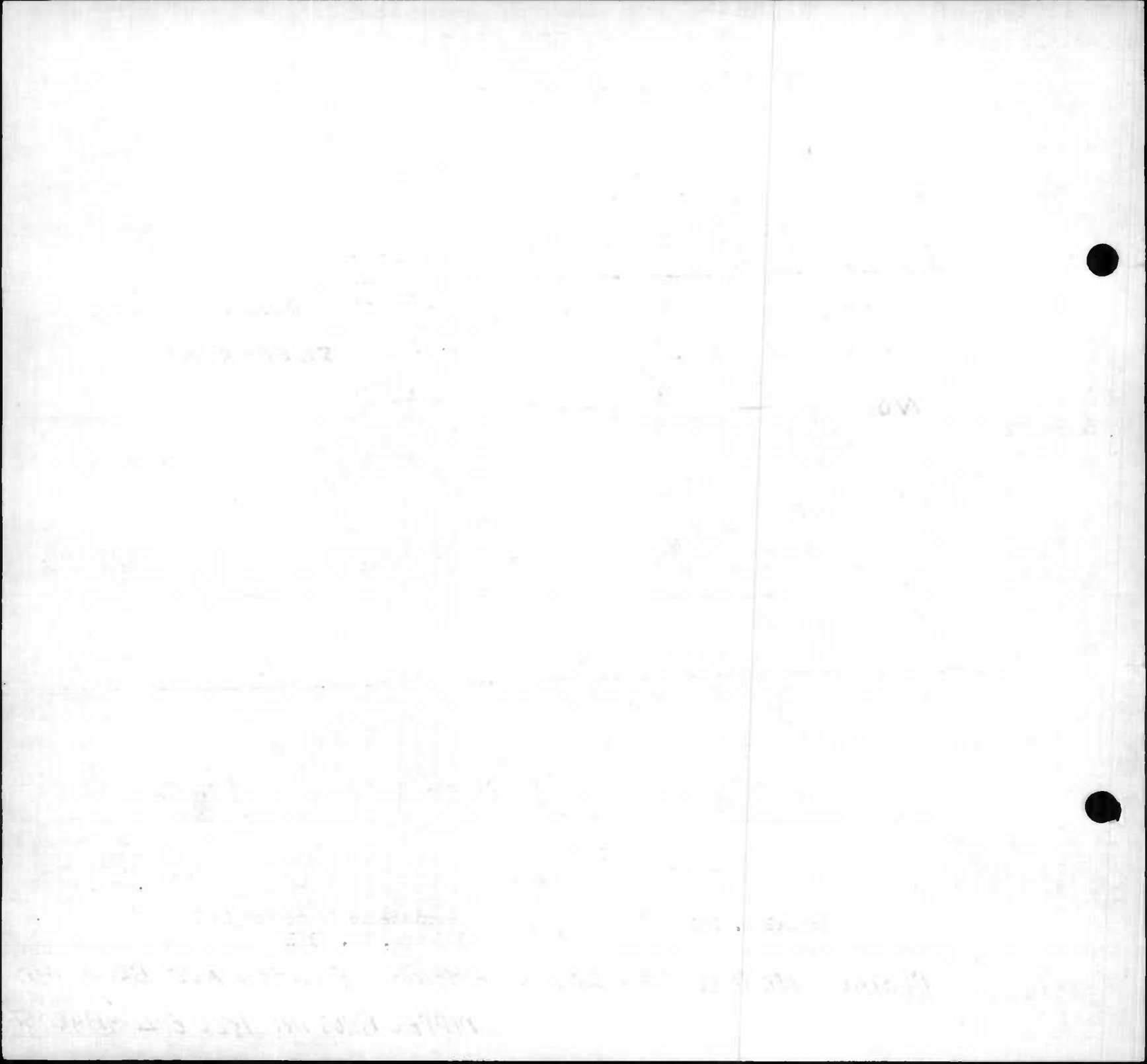
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
House in the Pines
Belair Road #6 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore Maryland
D. STREET ADDRESS (If rural, give location)
215 E. Penna. Ave. Bel Air Maryland 21014 | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
4-8-1868 | 9. AGE (In years last birthday)
98 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY
Housewife | | 11. BIRTHPLACE (State or foreign country)
Sweden | | |
| 13. FATHER'S NAME
Johan Backstrom | | | | 14. MOTHER'S MAIDEN NAME
Anna Maria Nielson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
L. Madeline Olsen 215 E. Penna. Avenue 21014 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) atherosclerosis
DUE TO
(B) coronary heart disease
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Mario E. Comas | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4-27-66 | |
| 23C. PHYSICIAN'S NAME (Type)
MARIO E. COMAS | | | | 23D. ADDRESS
5101 BELAIR Rd. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-27-1966 | | 24C. NAME OF CEMETERY or CREMATORY
St. James Cemetery | | 24D. LOCATION (City, town, or county) (State)
My Ladies Manor Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Lassahn Funeral Home 7401 Belair Rd | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|--|---|--|--|--|--|-------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>66 04412</u> | | | | |
| BIRTH NO. _____ | | | | | M.E. CASE NO. _____ | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Kilvinuck, Sophia</u> | | | | | 2. DATE AND HOUR OF DEATH
<u>4/25/66</u> <u>1:50 a.m.</u> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
<u>Montebello State Hospital</u> | | | | | A. STATE <u>Maryland</u> B. COUNTY <u>1-04</u> | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | | | |
| D. STREET ADDRESS (If rural, give location)
<u>2219 Essex St.</u> | | | | | | | | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH
<u>9/30/1898</u> | 9. AGE (In years last birthday)
<u>67</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Cook</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>SELF</u> | | 11. BIRTHPLACE (State or foreign country)
<u>unknown RUSSIA</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | |
| 13. FATHER'S NAME
<u>George Megenafsky</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary SWEDERSKI</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | | | 16. SOCIAL SECURITY NO.
<u>218-25-0902</u> | | 17. INFORMANT
<u>Hospital records</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
<u>332 X I</u> | | | | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) DUE TO
<u>Cerebral thrombosis & st. hemiplegia and Pseudo Rabies Polio</u> | | | <u>1 year</u> | |
| | | | | | (B) DUE TO
<u>unknown</u> | | | <u>unknown</u> | |
| | | | | | (C) DUE TO
<u>unknown</u> | | | <u>unknown</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/21/65</u> 19 to <u>4/25/66</u> 19, that (I) (we) last saw the deceased alive on <u>4/25/66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<u>Daniel G. Lai</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
<u>4/25/66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Daniel G. Lai</u> | | | | | 23D. ADDRESS
<u>Montebello State Hospital</u>
<u>Baltimore, Md. 21218</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>APR 30 66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>OAK LAWN CEMETERY</u> | | | 24D. LOCATION (City, town, or county) (State)
<u>EASTERN AVE. BLVD MD</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 2 1966</u> | | 25B. NAME OF REGISTRAR
<u>R. E. F. Adams</u> | | | 25C. FUNERAL DIRECTOR
<u>DIPPEL BRAS INC</u> | | | ADDRESS
<u>1800 E LOMBARD ST</u> | |



1
L-516

66 04413

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04413

| | | | |
|---|-------------------------|---|---|
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print)
PEARL JOSEPHINE LAMBERT | | 2. DATE AND HOUR PRONOUNCED DEAD
April 27, 1966 2:30 AM. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
JOHNS HOPKINS HOSPITAL - DOA | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1925 E. Pratt St. | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Married | 8. DATE OF BIRTH
March 13, 1925 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Work | | 10B. KIND OF BUSINESS OR INDUSTRY
At Home | 9. AGE (In years last birthday)
41 |
| 11. BIRTHPLACE (State or foreign country)
Burlington, West Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Dice Terry | | 14. MOTHER'S MAIDEN NAME
Minnie Rexford | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
Virgil Lambert |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Multiple Traumatic Injuries. | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) DUE TO | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
street | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
4-27-66 2:00 A.M. | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
1000' E. of Middle River Rd. - R.D. U.S. |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Pedestrian struck by truck | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
Rudiger Breitenecker, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
4-27-66 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
5-1-66 | 23C. NAME OF CEMETERY or CREMATORY
Fincham Chapel Cemetery |
| 24A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | 24B. NAME OF REGISTRAR
Robert E. Jackson | 24C. FUNERAL DIRECTOR
Charles A. Gailer |
| 24D. LOCATION (City, town, or county) (State)
Randolph County, West Virginia | | ADDRESS
901 S. CONKLING ST. BALTO., 24, MD. | |

MEDICAL CERTIFICATION

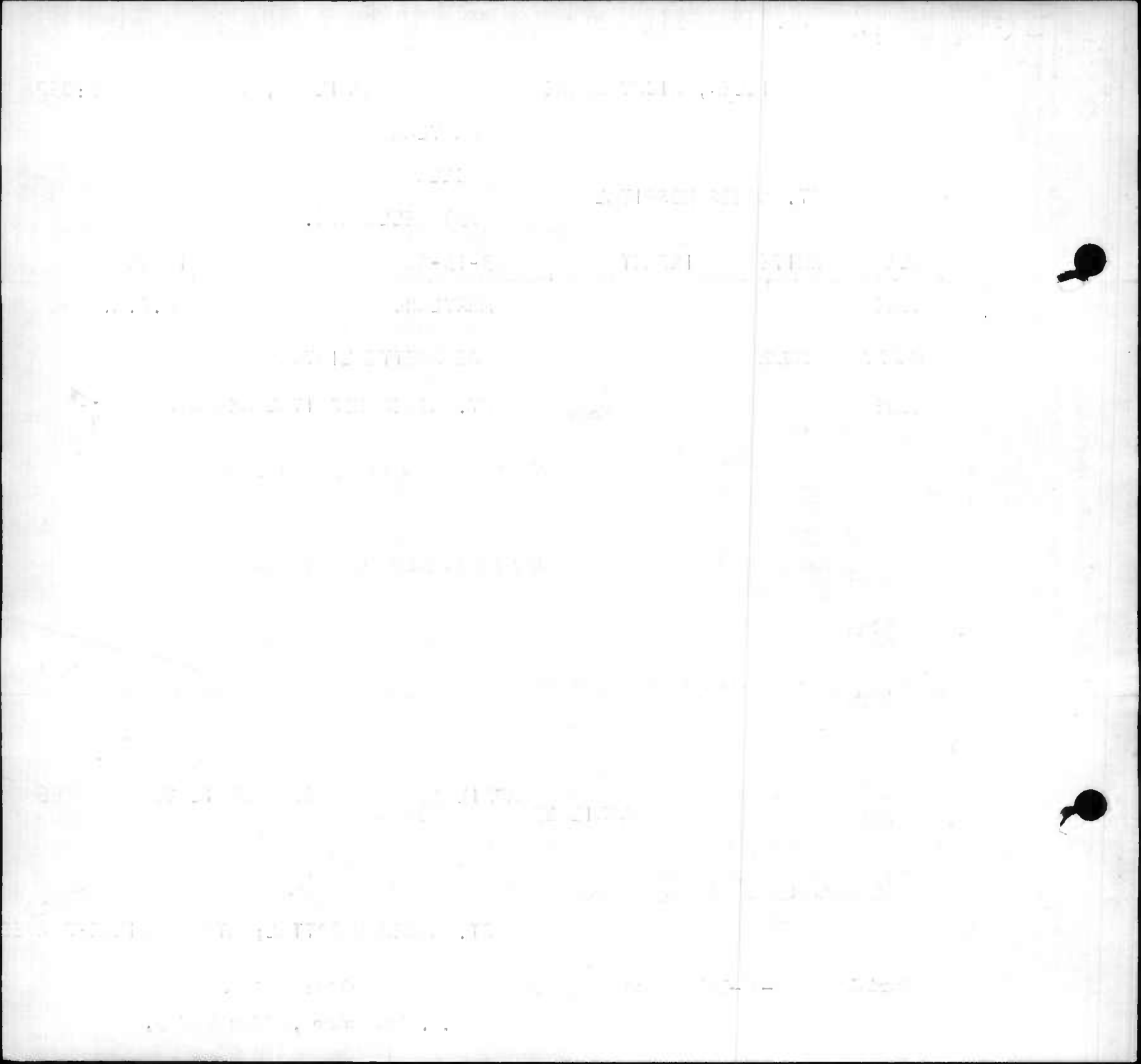
N 8692

WALTON 11-10-1907. 1-10-1907

FUNERAL DIRECTOR: IMPORTANT

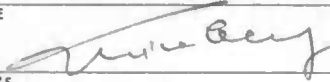
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>66 04414</u> | |
|---|---------|--|------------------|--|--|--|--|
| BIRTH NO. <u>66 05602</u> | | 66 04414 | | 2. DATE AND HOUR OF DEATH | | APRIL 27, 1966 3:05 P.M. | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) | | | |
| MILLER, RICKY DWANE | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| ST. AGNES HOSPITAL | | | | MARYLAND | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | OELLA | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 734 OELLA AVE. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| MALE | WHITE | INFANT | 3-13-66 | | 1 14 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| NONE | | | | MARYLAND | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| HARRY MILLER | | | | GEORGETTE LINTON | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NONE | | None | | ST. AGNES HOSPITAL RECORDS | | | |
| 18. <u>55-0,01</u> CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) <u>ENTEROCOLITIS, ACUTE</u> | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | DUE TO | | | |
| ANTECEDENT CAUSES | | | | (B) <u>ELECTROLYTE IMBALANCE</u> | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | DUE TO | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | <u>GANGRENOUS APPENDIX</u> | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| <u>4/26/66</u> | | <u>INTESTINAL OBSTRUCTION</u> | | <u>YES</u> | | <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>APRIL 18</u> 19 <u>66</u> to <u>APRIL 27</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>APRIL 27</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| <u>Michael E. Pelczar</u> | | | | | | <u>4/27/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| | | | | M.D. ST. AGNES HOSPITAL; CATON & WILKENS AVES #29 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>4-30-1966</u> | | <u>Good Shepherd</u> | | <u>Ellicott City, Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| <u>MAY 2 1966</u> | | <u>Robert E. Fink</u> | | <u>F.C. Higinbotham, Ellicott City, Md</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------------|--|---|---|---|--|---|--|--|
| BIRTH NO. 66 04415 | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. 66 04415 | | | | |
| 1. NAME OF DECEASED
(Type or Print) PHELPS, HELEN W. | | | | | 2. DATE AND HOUR OF DEATH
4. 26 1966 8 35 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Lutheran Hospital of Maryland | | | | | A. STATE MARYLAND B. COUNTY Anne Arundel | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
17 BALLMAN CT. #25 | | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
M | 8. DATE OF BIRTH
1/11/17 | 9. AGE (In years last birthday)
47 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
IBM Operator | | | 10B. KIND OF BUSINESS OR INDUSTRY
State of Maryland | | 11. BIRTHPLACE (State or foreign country)
Warm Springs, Va. | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Walter B. Ricks | | | | | 14. MOTHER'S MAIDEN NAME
Lillie L. LaRue | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
072-03-5107 | | 17. INFORMANT
Mr. Wilbert C. Phelps (Husband) | | | ADDRESS
Sec 45 #2 | |
| 18. 572.21
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Diarrhea, severe dehydration | | | | | (A) DUE TO
Aureus | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Ulcerative colitis, probable | | | | | (B) DUE TO | | | | |
| | | | | | (C) DUE TO | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
21 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4. 21 19 66 to 4. 26 19 66 , that (I) (we) last saw the deceased alive on 4. 26 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
 | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
GRUMBERG JOSEF | | | | | 23D. ADDRESS
Lutheran Hospital | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Apr. 30, 1966 | | 24C. NAME OF CEMETERY OR CREMATORY
Glen Haven Memorial Park | | | 24D. LOCATION (City, town, or county) (State)
Glen Burnie, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | | 25B. NAME OF REGISTRAR
R. V. Singleton | | | 25C. FUNERAL DIRECTOR
Singleton Funeral Home | | | |

47

State of Maryland
County of Prince George's
Shirley D. Smith

2

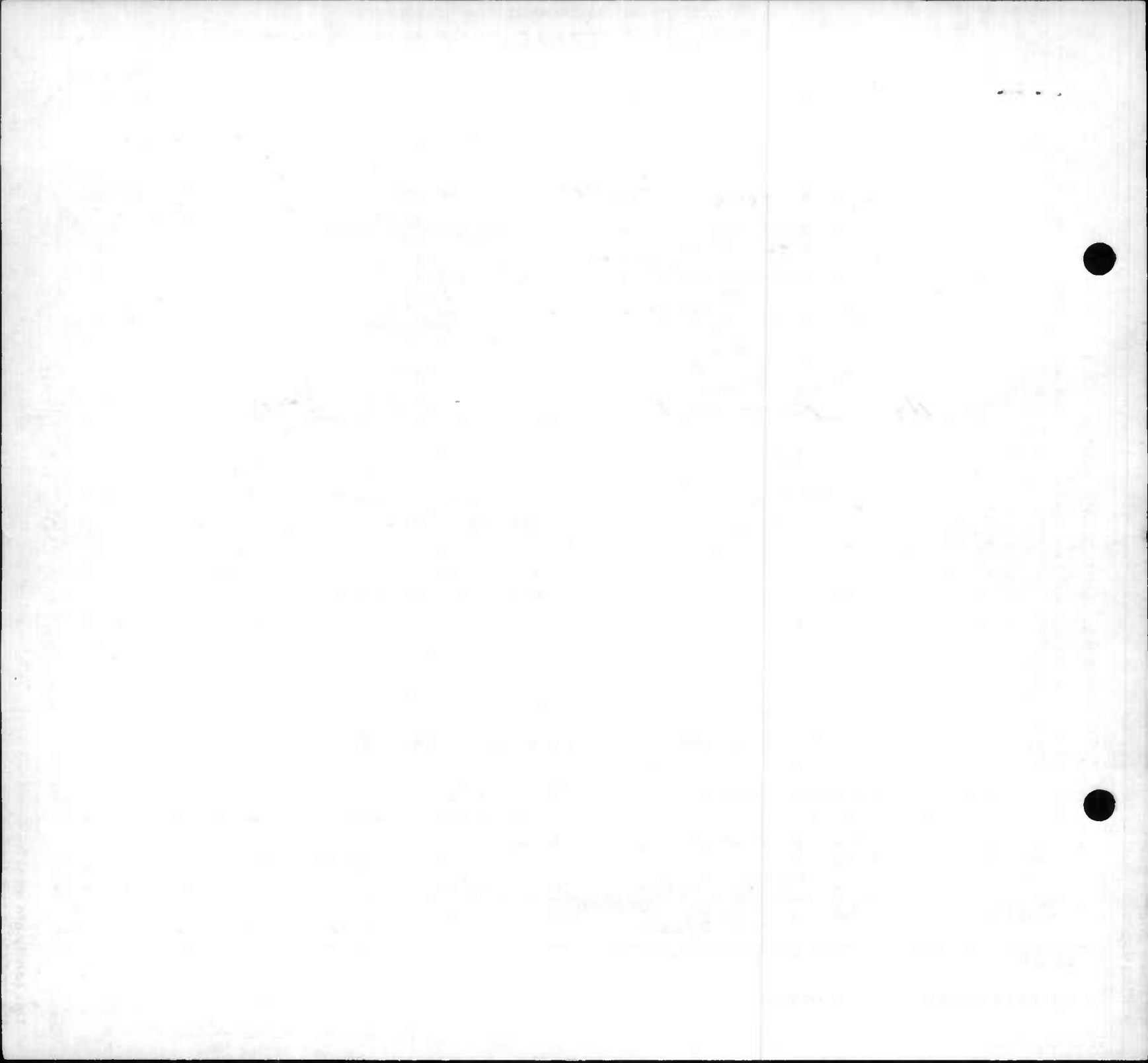
Shirley D. Smith

Shirley D. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|-----------------------------------|--|---|
| BIRTH NO.
66 04416 | | CITY HEALTH DEPARTMENT
BALTIMORE CITY | | REGISTERED NO. 66 04416 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print)
Richard W. Bender | | 2. DATE AND HOUR OF DEATH
April 28, 1966 12 PM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
Maryland
B. COUNTY
Anne Arundel | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Millersville 5200 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
48 Maryland General Hospital | | D. STREET ADDRESS (If rural, give location)
Box 149-A (Elvaton Road) | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
Oct. 28, 1909 | 9. AGE (In years last birthday)
56 | 10. IF UNDER 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Pressman | | 10B. KIND OF BUSINESS OR INDUSTRY
Waverly Press | | 11. BIRTHPLACE (State or foreign country)
Balto., Md. - | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Charles Bendet. | | 14. MOTHER'S MAIDEN NAME
Mary Howard | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-07-0125 | | 17. INFORMANT
Mrs. Anna Marie Bender (wife) Same As #2 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
420.1 I
ACUTE MYOCARDIAL INFARCTION | | CAUSE OF DEATH
(A) DUE TO
ACUTE MYOCARDIAL INFARCTION | | INTERVAL BETWEEN ONSET AND DEATH
Minutes | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (B) DUE TO
CHRONIC HEART DISEASE 1-2 years | | | |
| (C) _____ | | | | | |
| MEDICAL CERTIFICATION | | 19A. DATE OF OPERATION
O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/16 1965 to 4/28 1966, that (I) (we) last saw the deceased alive on 4-7 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Hilary T. Oherlidy | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/29/66 | |
| 23C. PHYSICIAN'S NAME (Type)
HILARY T. OHERLIDY | | 23D. ADDRESS
5 CENTRAL AVE, GLEN BURNIE MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
May 2, 1966 | | 24C. NAME OF CEMETERY or CREMATORY
Glen Haven Mem. Park | |
| 24D. LOCATION
Glen Burnie, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 R.E. E. Fickel | | 25B. NAME OF REGISTRAR
R. V. Singleton | |
| 25C. FUNERAL DIRECTOR
R. V. Singleton | | ADDRESS
Singleton Funeral Home
Glen Burnie, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

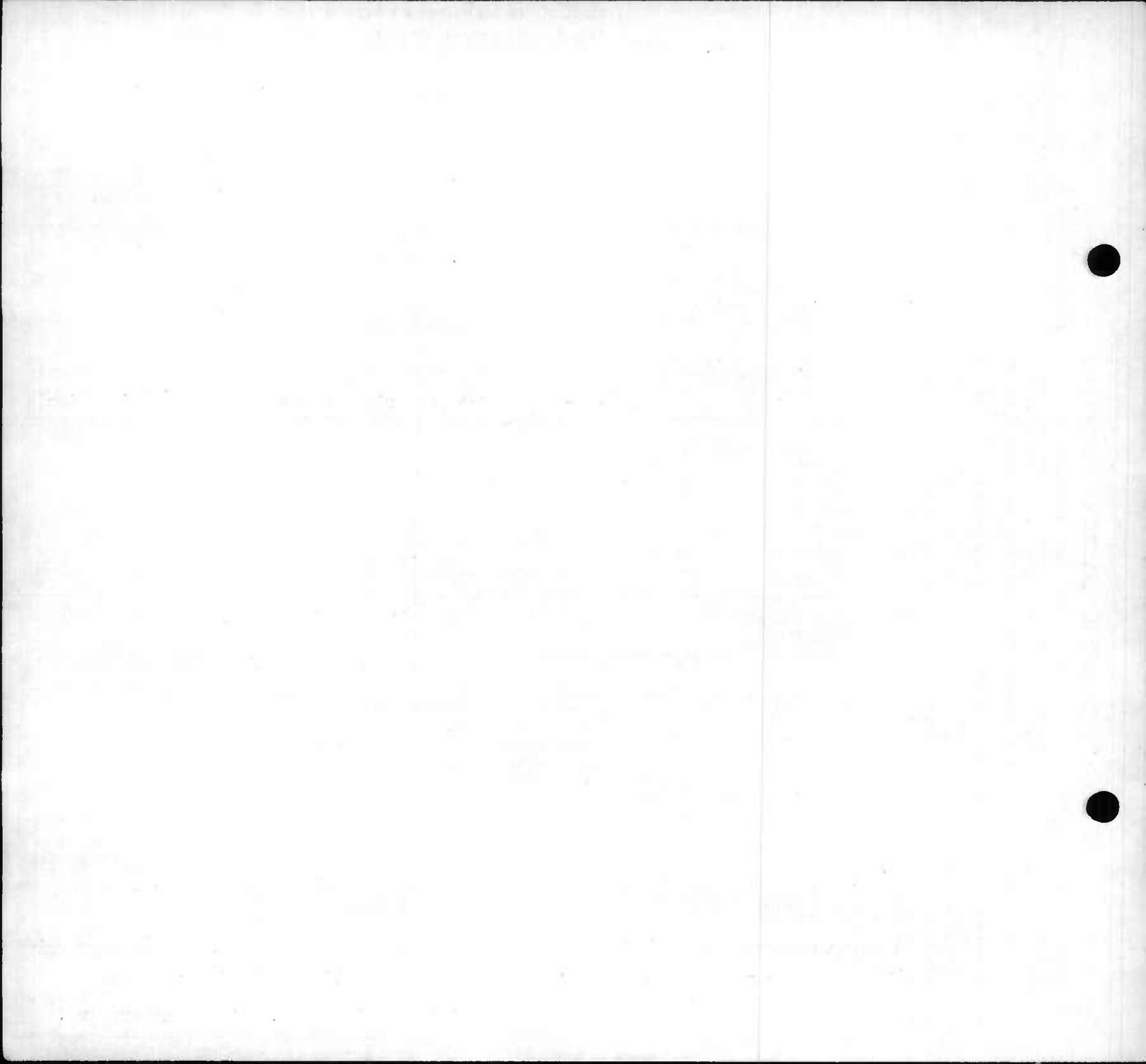
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

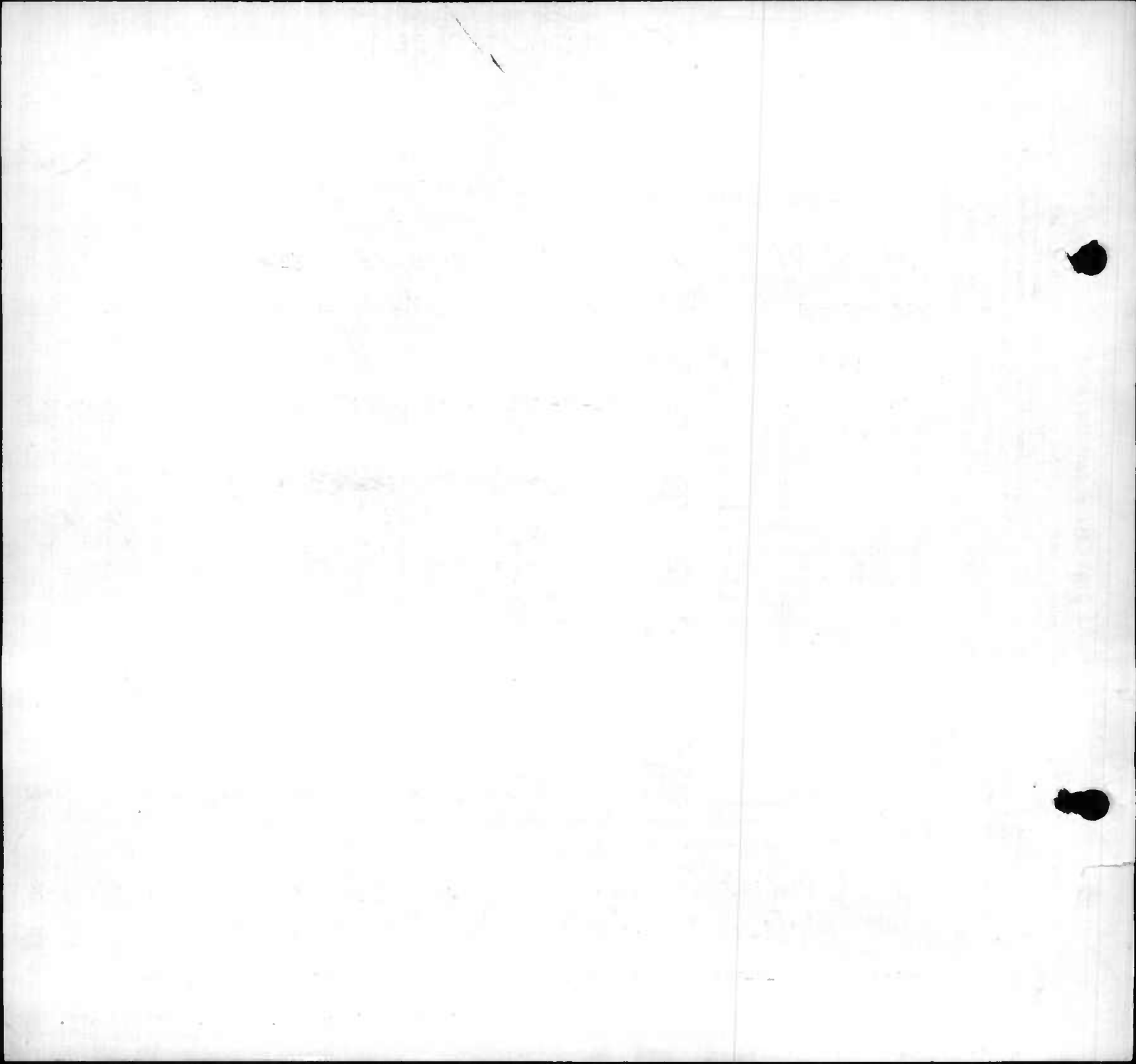
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|--|---------------------|--|--|--|--|--|--|--|---|--------------------------------|--|
| BIRTH NO. 66 04417 | | MARIE M. WAGNER | | | | CERTIFICATE OF DEATH | | | | Registered No. 66 04417 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) MARIE M. WAGNER | | | | 2. DATE AND HOUR OF DEATH
30 April 66 8⁰⁰ P. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Maryland General Hospital | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2518 East Ave. | | | | | |
| 5. SEX
♀ | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
never married | | 8. DATE OF BIRTH
Oct. 18, 1900 | | 9. AGE (In years last birthday)
65 | | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Machine Operator | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Continental Can | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | | |
| 13. FATHER'S NAME
Michael Wagner | | | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth Haas | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
214-03-2650 | | 17. INFORMANT ADDRESS
Mrs Catherine Peterson 1040 Marleigh Circle | | | | | |
| 18. 525X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | CAUSE OF DEATH
(A) Respiratory failure
DUE TO
(B) Pulmonary fibrosis
DUE TO
(C) | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 19 1966 to April 30 1966 , that (I) (we) last saw the deceased alive on April 30 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Richard P. Norgaard | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED
30 April 66 | | |
| 23C. PHYSICIAN'S NAME (Type)
RICHARD P. NORGAARD | | | | 23D. ADDRESS
Maryland General Hospital | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-4-1966 | | 24C. NAME OF CEMETERY or CREMATORY
Sacred Heart | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore County, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Lilly & Zeiler Inc. | | | | ADDRESS
1901 Eastern Ave. | | | |





MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

Carrie (Evans) Wilder

2. DATE AND HOUR PRONOUNCED DEAD

4/27/66 9:20 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

14 W. Pine St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

March 3, 1915 51

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Luther Patrick

14. MOTHER'S MAIDEN NAME

Ruth Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. H.S. Green Lake City S.C.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Acute lepto-meningo-myelitis, cervical
-DUE TO- spinal cord

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

Due to

(B) Osteomyelitis (pneumococcus), cervical
DUE TO vertebrae

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type) Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/28/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

May 3, 1966 St Mark Cemetery

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Olanda, S.C.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 2 1966

Wm C March 928 E. North Ave.

VALLEY FORD

PROCESSION

U.S.A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--------------|---|------------------------------------|--|--|
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04420 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) | | LELA GAMBLE | | 2. DATE AND HOUR OF DEATH
April 28, 1966 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | MARYLAND
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| UNION MEM HOSPITAL | | D. STREET ADDRESS (If rural, give location)
407 E 20th St | | | |
| 5. SEX
Female | 6. RACE
C | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
April 10, 1900 | 9. AGE (In years last birthday)
66 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
South Carolina | |
| 13. FATHER'S NAME
Alex Coleman | | 14. MOTHER'S MAIDEN NAME
Clara Fenigan | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mrs Lula Allen 407 E 20th St | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease or injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO
Cerebral Vascular Accident with hypertension
Hypertensive Vascular disease
Obesity - arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
10-12 | |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from August 7, 1961 to January 4, 1966, that (I) was lost saw the deceased alive on Jan - 4 - 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Dr. Herman Seidel | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
Apr 29, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
Herman Seidel, M. D. | | 23D. ADDRESS
M.D. 2404 Eutaw Place, Balto, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/1/66 | | 24C. NAME OF CEMETERY or CREMATORY
Mt Auburn Cemetery | |
| 24D. LOCATION
Baltimore Md | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Talbot | | 25C. FUNERAL DIRECTOR ADDRESS
Adolphus Halstead 1206 W North Ave | | | |

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

ALEXANDER McCREE

2. DATE AND HOUR PRONOUNCED DEAD

4-25-66 15:45 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1217 N. GILMORE STREET

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1217 N. Gilmore Street 21217

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

George McCree

14. MOTHER'S MAIDEN NAME

Katie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Alberta Henson 4010 Norfolk Ave

| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN
ONSET AND DEATH |
|--|---|--|---|-------------------------------------|
| <div>18.1 DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)</div> <div>(A) Aortic insufficiency
DUE TO</div> <div>18.2 ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.</div> <div>(B) Luetic heart disease
DUE TO</div> <div>(C)</div> | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT. | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? | |
| | | Yes | Yes | |
| 21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) | | |
| 21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME
OF INJURY
(APPROX.) | (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? |
| | | WHILE AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input type="checkbox"/> | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion
resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL
SIGNATURE | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED |
| EXAMINER'S
NAME (Type) | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 4-25-66 |
| ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| RUSSELL S. FISHER, M.D. | | | | |
| 23A. BURIAL CREMATION,
REMOVAL (Specify) | 23B. DATE | 23C. NAME of CEMETERY or CREMATORY | 23D. LOCATION (City, town, or county) (State) | |
| Burial | 5/2/66 | Mt Calvary Cemetery | A A County Md | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | 24C. FUNERAL DIRECTOR ADDRESS | |
| MAY 2 1966 | | Robert E. Fisher | Adolphus Halstead 1206 W North Ave | |

WALLLEY HORGE

RAD. CONTROL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------|--|--|--|---|--|---|----------------------------------|---|
| Certificate of Death | | | | | Registered No. 66 04422 | | | | |
| BIRTH NO. 66 04422 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) SPENCER, Sarah | | | | | 2. DATE AND/HOUR OF DEATH 4/30/1966 1:10 M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Montebello State Hosp. | | | | | A. STATE Maryland B. COUNTY USA | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 14-02 | | | | |
| D. STREET ADDRESS (If rural, give location) 1426 Madison Ave | | | | | | | | | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) ? | | 8. DATE OF BIRTH 1/31/1904 | 9. AGE (In years last birthday) 62 | 10. Under 1 Yr. Months Days | | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 0 | | | | | 10B. KIND OF BUSINESS OR INDUSTRY 0 | | 11. BIRTHPLACE (State or foreign country) Richmond, Va | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME ? | | | | | 14. MOTHER'S MAIDEN NAME ? | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. No | | 17. INFORMANT ADDRESS Baltimore | | |
| | | | | | Barbara Shipley | | | 2442 Morsel Court, | |
| 18. 156.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | (A) Congestive Heart Failure
DUE TO | | | 2 yrs | |
| | | | | | (B) Carcinoma of liver
DUE TO | | | 2 yrs | |
| | | | | | (C) | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0 | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 28 1966 to April 30 1966 , that (I) (we) last saw the deceased alive on April 29 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Hea Rean LEW M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 4/30/66 | |
| 23C. PHYSICIAN'S NAME (Type) Hea Rean LEW M.D. | | | | | 23D. ADDRESS Montebello State Hosp. Baltimore | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5/2/66 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery | | 24D. LOCATION (City, town, or county) A A County Md | | (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 2 1966 | | 25B. NAME OF REGISTRAR Adolphus Halstead | | 25C. FUNERAL DIRECTOR Adolphus Halstead | | ADDRESS 1206 W North Ave | | | |



BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED
(Type or Print)

Bernard Davis

2. DATE AND HOUR PRONOUNCED DEAD

Friday 4/29/66

3:00 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

577 Oxford Street, Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

725 George Street Apt 9 P

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Sept 10, 1927

9. AGE (In years
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Miss Sadie Smith 725 George St

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Bronchopneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.Fatty Alteration of Liver with early cirrhosis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Partial Autopsy

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
If in Baltimore City, give exact location21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Werner U. Spitz, M. D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/30/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5/3/66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

A A County Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 2 1966

24B. NAME OF REGISTRAR

Robert E. Feltus

24C. FUNERAL DIRECTOR

ADDRESS

Adolphus Halstead 1206 W North Ave

WILLIAM H. HARRIS

1874

1874

1874

1874

1874

1874

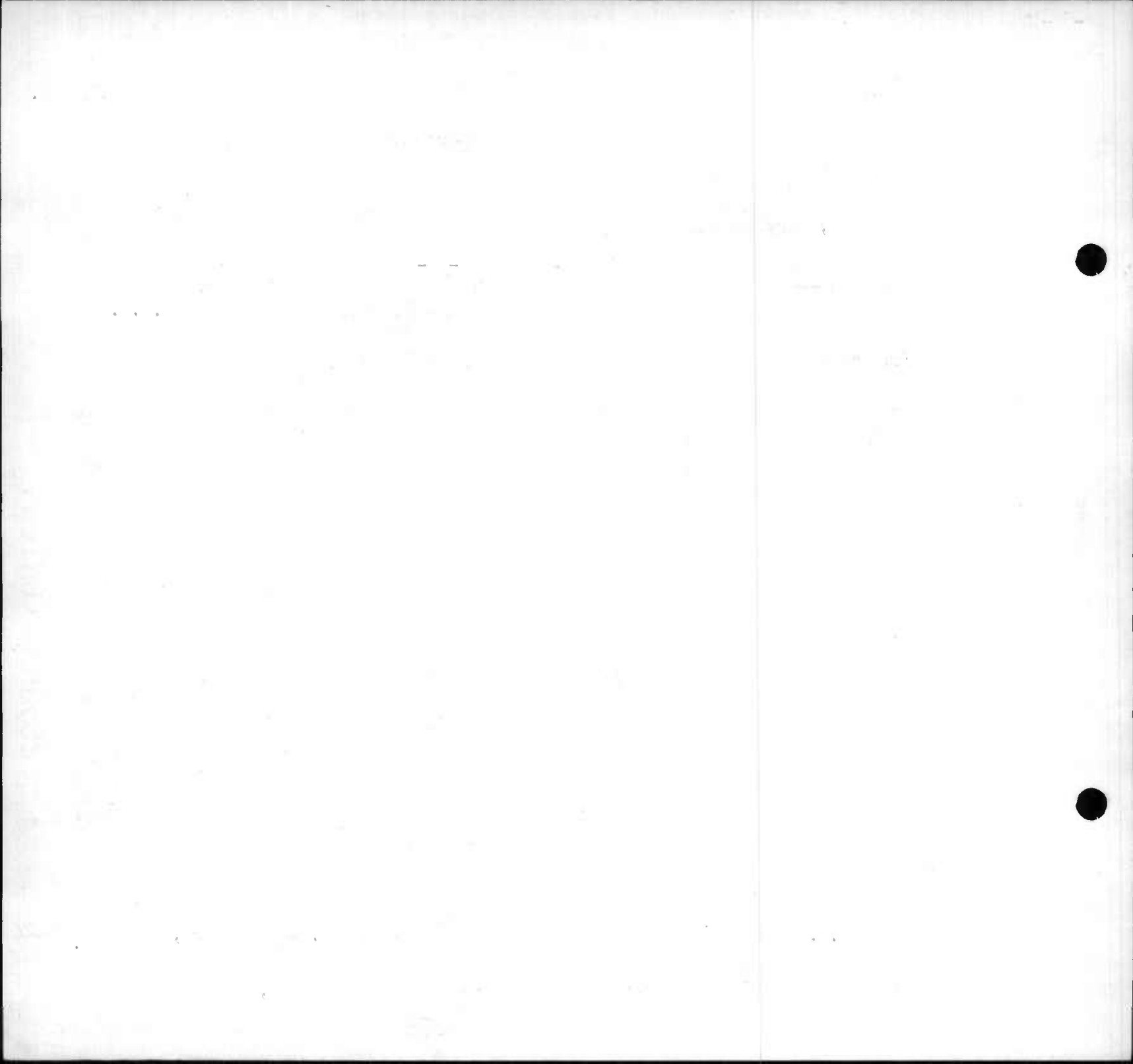
1874

1874

1874

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|--|--|
| WY 416
66 04424 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04424 | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| EVA Florence Wolverton | | 4/27/66 | | 1:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | Maryland | | 27-05 | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| Female | | White | | Widowed | |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. CITIZEN OF WHAT COUNTRY? | |
| 8-30-85 | | 80 | | U.S.A. | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| West Virginia | | U.S.A. | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Berle Brown | | Isabel Weakley | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | ? | | RECORDS: BCH: 4940 Eastern Avenue
Baltimore, Maryland 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | 1 wk | |
| ANTECEDENT CAUSES | | (B) DUE TO | | 5cl | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) | |
| 0 | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/24 1966 to 4/26 1966, that (I) (we) last saw the deceased alive on 4/26 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| H.D. Albert | | 4/27/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| H.D. Albert | | Baltimore City Hospitals
4940 Eastern Ave. - Baltimore, Maryland 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 4/30/66 | | Woodlawn Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| MAY 2 1966 | | R. E. Taylor, M.D. | | Austin E. Honoran - 3818 Roland Ave | |



1
L 200

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

66 04425

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04425

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Jerry Leach

2. DATE AND HOUR PRONOUNCED DEAD

4/28/66 2:10 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

South Baltimore General

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

918 Honaker Ct.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

2/7/29

9. AGE (In years
last birthday)

37

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

TENN.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

YES

1947 - 1950

16. SOCIAL
SECURITY NO.

408-58-2537

17. INFORMANT

ADDRESS

RUTH LEACH 914 HONAKER COURT

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

street

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

Patapsco Ave. near 9th St.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
4 27 66 8:50a.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

pedestrian struck by auto

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/28/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

1/2/66

23C. NAME OF CEMETERY or CREMATORY

NATIONAL

23D. LOCATION

(City, town, or county)

BALTO. MD.

24A. DATE REC'D BY HEALTH DEPT.

MAY 2 1966

24B. NAME OF REGISTRAR

E. J. Fisher, M.D.

24C. FUNERAL DIRECTOR

Paul E. Chevone

ADDRESS

3617 Chestnut Ave.

WALLS WIPORITE

AND CEMENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 04426</u> | |
|---|----------------------------|--|--|--|--|
| BIRTH NO. <u>66 04426</u> | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <u>JAMES GARFIELD SMITH</u> | | | <u>29 APRIL 1966</u> <u>3:30 P</u> M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>UNION MEMORIAL HOSPITAL</u> | | | A. STATE <u>MD.</u> B. COUNTY <u>13-07</u> | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | | |
| | | | D. STREET ADDRESS (If rural, give location)
<u>716 W. 36th St.</u> | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>19 DEC '84</u> | 9. AGE (In years last birthday)
<u>81</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>RETIRED</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
<u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> |
| 13. FATHER'S NAME
<u>UNK.</u> | | | 14. MOTHER'S MAIDEN NAME
<u>SARAH</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>229-75-9405</u> | 17. INFORMANT ADDRESS
<u>MAGGIE SMITH-WIFE-SAME</u> | | |
| 18. <u>420.1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>MYOCARDIAL INFARCTION</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Several hours</u> | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>30 years</u> | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY (Yes or No)
<u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that <u>he</u> (this hospital) attended the deceased from <u>21 April</u> 19 <u>66</u> to <u>29 April</u> 19 <u>66</u> , that <u>we</u> last saw the deceased alive on <u>29 April</u> 19 <u>66</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>We</u> (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>L. Evan Custer</u> | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>29 April '66</u> |
| 23C. PHYSICIAN'S NAME (Type)
<u>L. EVAN CUSTER</u> | | | 23D. ADDRESS
M.D. <u>UNION MEMORIAL HOSPITAL</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 24B. DATE
<u>5/2/66</u> | 24C. NAME OF CEMETERY or CREMATORY
<u>LORRAINE</u> | 24D. LOCATION (City, town, or county) (State)
<u>BALTO. MD.</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 2 1966</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Salkin, M.D.</u> | 25C. FUNERAL DIRECTOR ADDRESS
<u>Paul E. Charney, F.D.</u>
<u>3617 Chestnut Av.</u> | | |

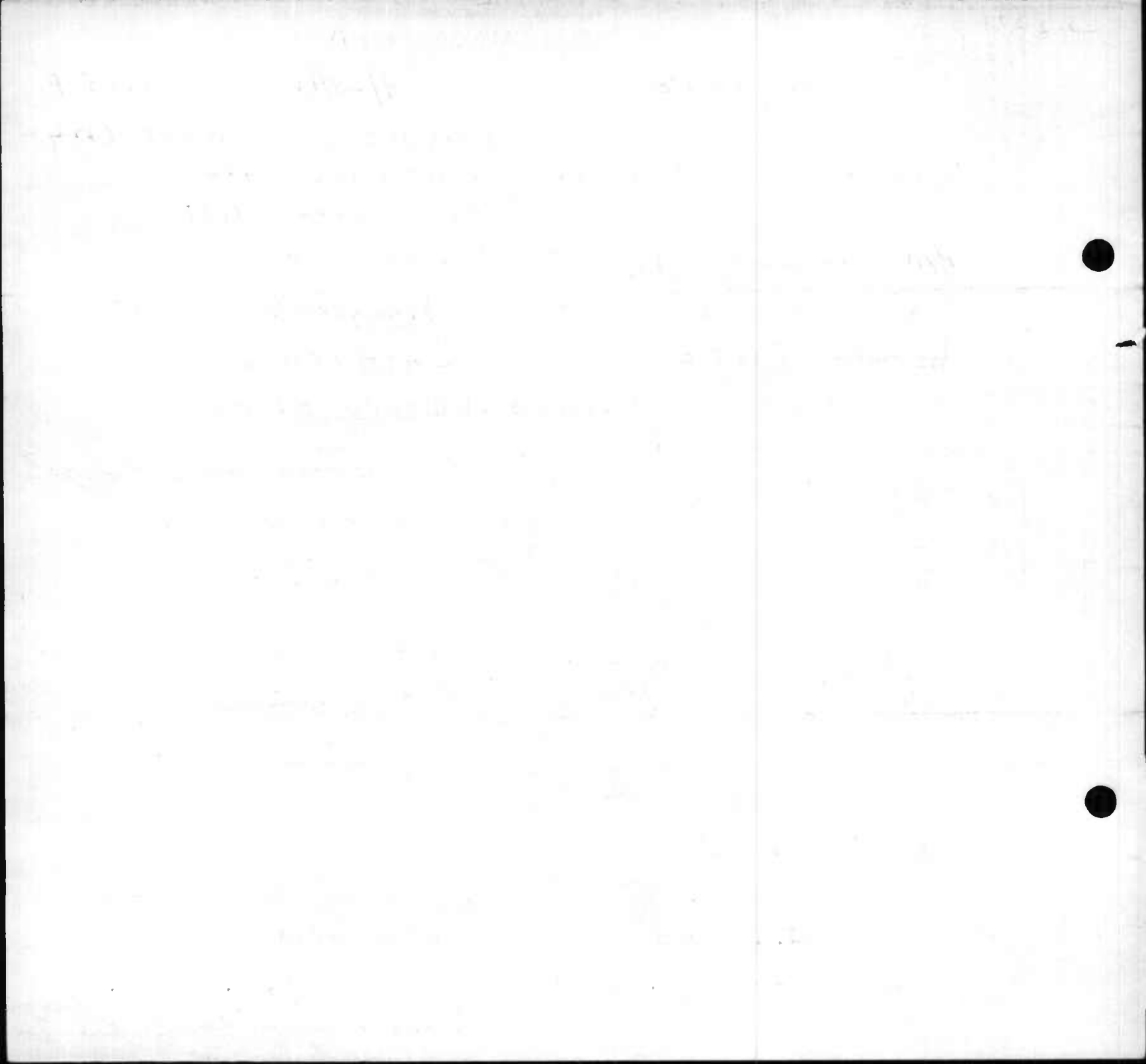
THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------------------------|---|------------------------------------|---|---|
| BIRTH NO. <u>66 04427</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>66 04427</u> | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>OSCAR DIETZ</u> | | 2. DATE AND HOUR OF DEATH
<u>4/28/66</u> <u>7:55 P.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF INSTITUTION
<u>CHURCH HOME & HOSPITAL</u> | | A. STATE <u>MARYLAND</u>
B. COUNTY <u>BALTIMORE CITY</u> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE CITY</u> <u>5300</u> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>3407 JOPPA ROAD</u> | | | |
| 5. SEX
<u>MALE</u> | 6. RACE
<u>CAUCASIAN</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>7-27-08</u> | 9. AGE (In years last birthday)
<u>57</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>CARPENTER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>CARPENTER</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | 13. FATHER'S NAME
<u>Christian</u>
<u>VERNON DIETZ</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>CATHARINE HANE</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>212-09-3673</u> | | 17. INFORMANT
<u>ADMISSION HISTORY</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<u>451X1</u>
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH
(A) <u>Ruptured aortic aneurysm</u>
DUE TO
(B) <u>Arteriosclerotic cardiovascular</u>
DUE TO
(C) <u>disease</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>1-2 days?</u> | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>4/19/66</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>ORTIC OCCLUSIVE DISEASE; RTD CA PANCREAS</u> | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<u>NO</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>I. R. Anderson</u> | | 23B. DATE SIGNED
<u>4-29-1966</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>Dr I.A. Anderson</u> | |
| 23D. ADDRESS
<u>Church Home Hospital</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | |
| 24B. DATE
<u>5-1-1966</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>St. Michael's Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Co. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 2 1966</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Fisher</u> | | 25C. FUNERAL DIRECTOR
<u>Lassafin Funeral Home</u> | |
| | | | | ADDRESS (36)
<u>7401 Belair Road</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|--|--|---|---|---|--|------------------------------------|--|
| BIRTH NO. 66 04428 | | | | | CERTIFICATE OF DEATH | | | Registered No. 66 04428 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) KAROLINE F. PERNER | | | | | 2. DATE AND HOUR OF DEATH
April 28, 1966 11:30 p. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Harford Gardens Nursing Home | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md., B. COUNTY 21205
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 809 N. Lakewood Ave. | | | | |
| 5. SEX
female | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
widowed | 8. DATE OF BIRTH
7/14/1878 | | 9. AGE (In years last birthday)
87 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY
at home | | 11. BIRTHPLACE (State or foreign country)
Czechoslovakia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
Steven Hranicka | | | | | 14. MOTHER'S MAIDEN NAME
unknown | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO.
216-10-9346B | | 17. INFORMANT Baltimore, 20, Md. ADDRESS
Mrs. Carolyn McNelly, Box 738, Rt. 15 | | | | |
| 18. 420.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Anteroklatic Heart disease
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Broncho-pneumonia
Generalized Osteo-arthritis | | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
II | | | | | INTERVAL BETWEEN ONSET AND DEATH
?
4 days
? | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 50 to April 28 19 66 , that (I) (we) last saw the deceased alive on April 25 19 66 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Louis Klimes | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED
4/29/66 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Louis Klimes | | | | | 23D. ADDRESS
M.D. 4814 Bowleys Lane | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/30/66 | | 24C. NAME OF CEMETERY or CREMATORY
Bohemian National Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | | 25B. NAME OF REGISTRAR
Robert E. Saker, M.D. | | | 25C. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
3331 Brehms Lane | | | |

1. The first part of the paper

is devoted to a general

discussion of the subject

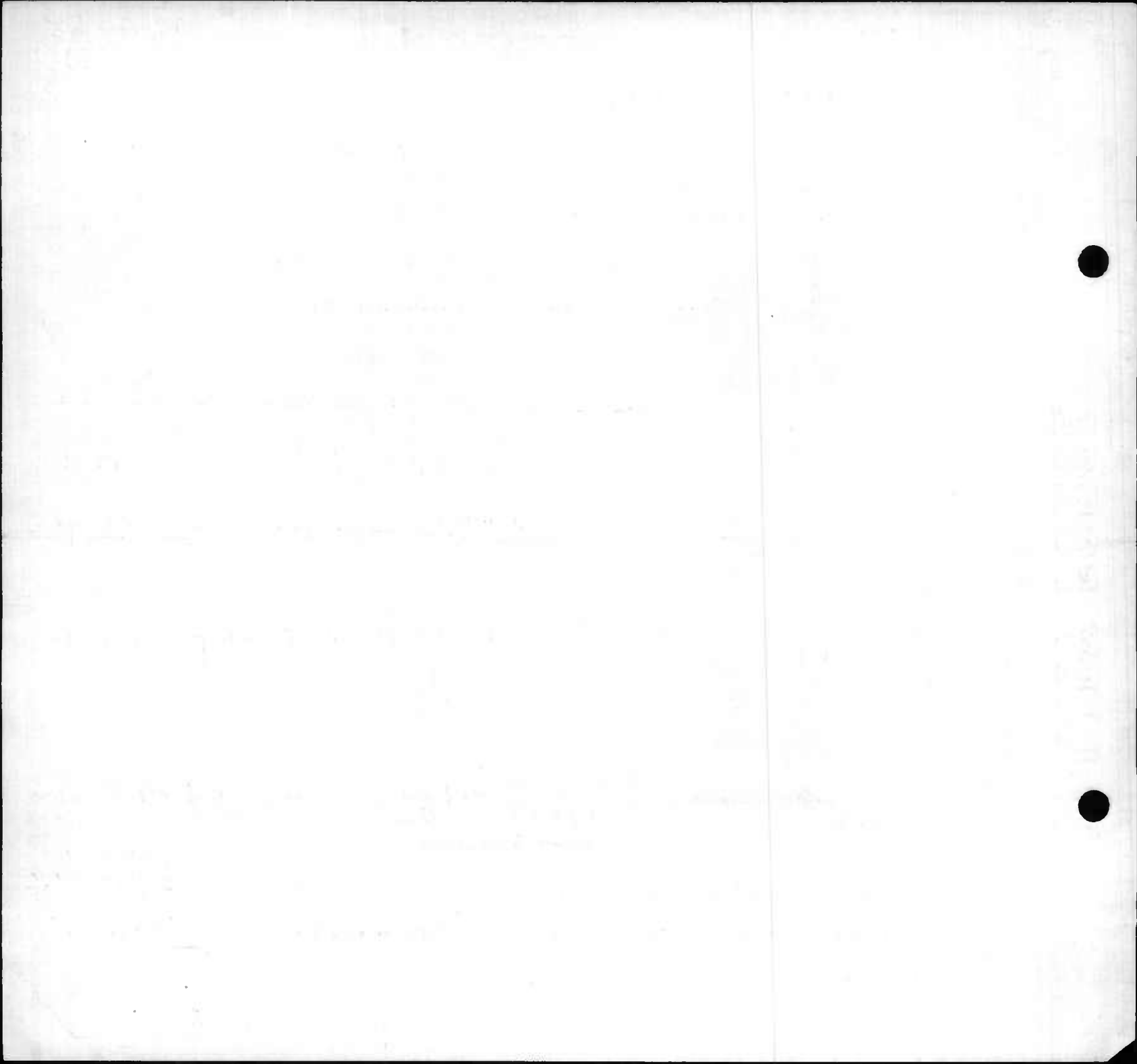
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 464258 | |
|---|--------------|---|--|--|---|
| BIRTH NO. 66 04429 | | | | 66 04429 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) JOHN E. Wright | | | 2. DATE AND HOUR OF DEATH
4/27/66 1 7:50 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 26Y-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 4428 Clareway | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
m | 8. DATE OF BIRTH
10-11-09 | 9. AGE (In years
last birthday)
56 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bottling Dept. | | | 10B. KIND OF BUSINESS OR INDUSTRY
Arrow Brewery | | 11. BIRTHPLACE (State or foreign country)
MARYLAND m Baltimore |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | |
| 13. FATHER'S NAME
HARRY WRIGHT | | | 14. MOTHER'S MAIDEN NAME
MARY HOGAN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | 16. SOCIAL SECURITY NO.
213-03-1423 | | |
| 17. INFORMANT
RECORDS: BCH 4940 EASTERN AVENUE #21224 | | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
260X I
Pneumonia, RLL
Diabetes mellitus
INTERVAL BETWEEN ONSET AND DEATH
12d
26 yr. | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | |
| 19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Cerebral vascular insufficiency 1 mo. | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No)
NO | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 4/12 1966 to 4/27 1966, that (1) (we) last saw the deceased alive on 4/27 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
D. E. Gaasterland | | | 23B. DATE SIGNED
4/27/66 | | |
| 23C. PHYSICIAN'S NAME (Type)
D. E. GAASTERLAND | | | 23D. ADDRESS
BALTIMORE City Hosps. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 24B. DATE
4/30/66 | | |
| 24C. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | | 25B. NAME OF REGISTRAR
Schimunek Funeral Home, Inc. | | |
| 25C. FUNERAL DIRECTOR
3331 Brehms Lane | | | ADDRESS | | |



1
S 365

66 04430

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04430

| | | | |
|---|--|--|--|
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| Josephine Sterner | | 4/28/66 10:35 a. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE
Maryland | |
| Hopkins Hospital | | B. COUNTY
7-01 | |
| 5. SEX
female | | 6. RACE
white | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
married | | 8. DATE OF BIRTH
9/24/1901 | |
| 9. AGE (In years last birthday)
64 | | 10. If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
at home | |
| 11. BIRTHPLACE (State or foreign country)
Czechoslovakia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Zarub Mergle | | 14. MOTHER'S MAIDEN NAME
unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
George J. Sterner, husband, above | | ADDRESS | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER
M.D. ASSISTANT MEDICAL EXAMINER
ASSOCIATE MEDICAL EXAMINER | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
5/2/66 | |
| 23C. NAME OF CEMETERY or CREMATORY
Gardens of Faith Cem. | | 23D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 24A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | 24B. NAME OF REGISTRAR
Schimunek Funeral Home, Inc.
2601 E. Madison St. | |

VALLEY SPONGE

MADE IN U.S.A.

100% COTTON

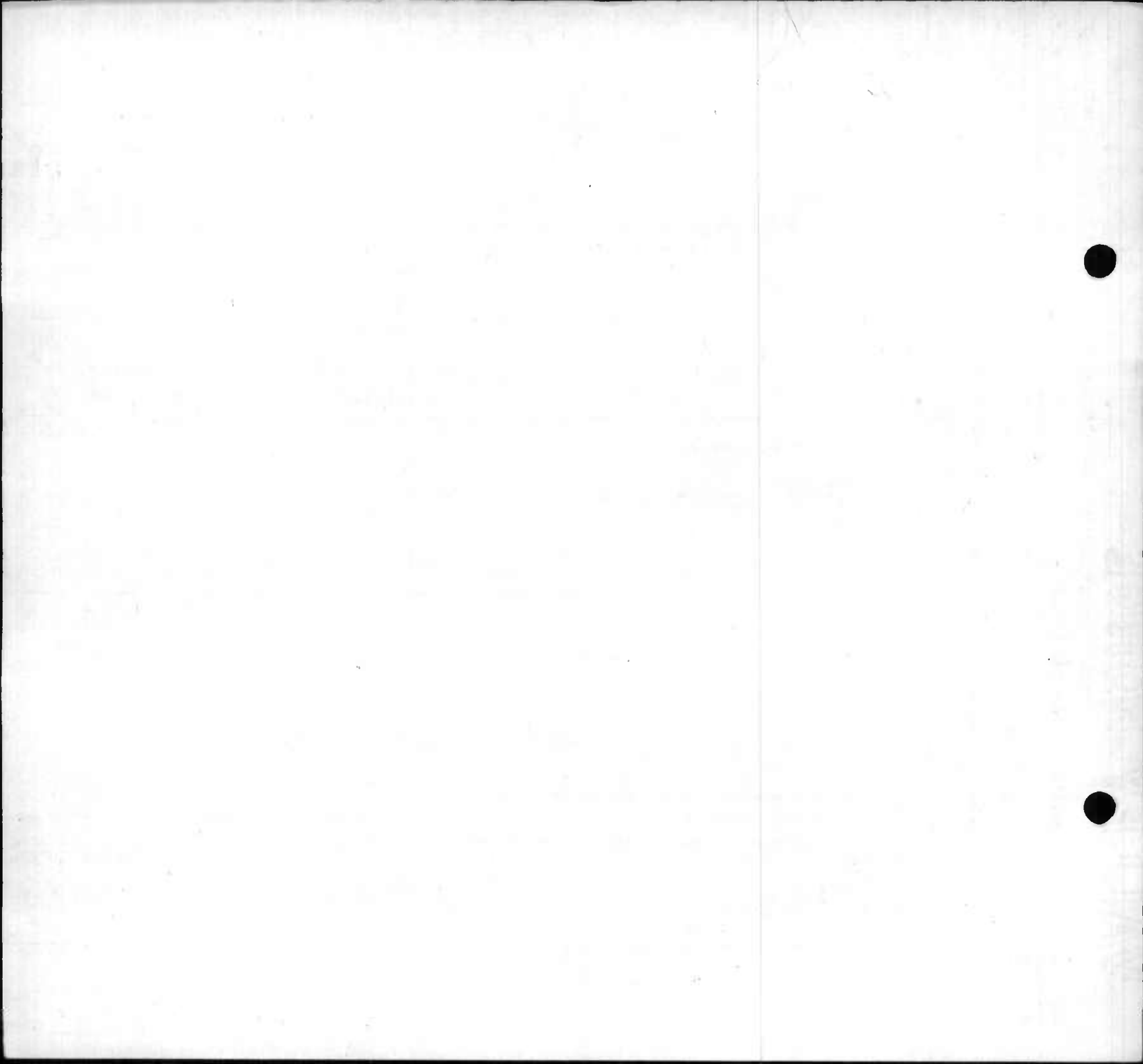
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 04431 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 04431 | |
|---|---------------------|--|---|---|--|--|------------------------|--|--|
| 1. NAME OF DECEASED
(Type as Print) CARL JOHN KURTZ | | | | 2. DATE AND HOUR OF DEATH
APR. 28/66 1:30 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital at institution, give street address or location)
36 FRANKLIN SQ. HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27
D. STREET ADDRESS (If rural, give location) 53-00
2221 SMITH AVE. | | | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
M | 8. DATE OF BIRTH
4-12-06 | 9. AGE (In years last birthday)
60 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
ANDREW KURTZ | | | 14. MOTHER'S MAIDEN NAME
EMMA RACOB | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
212 14 3913 | | 17. INFORMANT
PAH. / y | | ADDRESS
Same | | |
| 18. 13-4 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) Carcinoma, Rectum w/ gen. metastasis
DUE TO
(B) _____
DUE TO
(C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-25 1966 to 4-28 1966 , that (I) (we) lost saw the deceased alive on 4-28-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
S.B. Luague | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4-28-66 | | | |
| 23C. PHYSICIAN'S NAME (Type)
S.B. LUAGUE | | | | 23D. ADDRESS
M.D. FRANKLIN SQUARE HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-30-66 | | 24C. NAME OF CEMETERY or CREMATORY
Lakewood Cem. | | 24D. LOCATION (City, town, or county) (State)
Ind | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | 25B. NAME OF REGISTRAR
John E. Taylor | | 25C. FUNERAL DIRECTOR
McCully Funeral Home 1378 Patuxent Ave | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | Registered No. 66 04432 | |
|---|---------------------|---|-------------------------------------|--|---|
| BIRTH NO. 66 04432 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Harold A. Smith | | 2. DATE AND HOUR OF DEATH
4-30-66 4:45 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY A. A. County | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
South Baltimore General Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Brooklyn Park | | | |
| | | D. STREET ADDRESS (If rural, give location)
4400 Belle Grove Rd. 25 | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
5-3-1890 | 9. AGE (In years last birthday)
75 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired - Machanic | | 10B. KIND OF BUSINESS OR INDUSTRY
Revere Brast & Copper | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | |
| 13. FATHER'S NAME
Judson H. Smith | | 14. MOTHER'S MAIDEN NAME
Anna Askew | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Miss Anne E. Smith | |
| | | | | ADDRESS
1305 Highland Dr. | |
| 18. 327.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
PLC MOLAR EMBRYSEMA | | CAUSE OF DEATH
(A) DUE TO
PLC MOLAR EMBRYSEMA | | INTERVAL BETWEEN ONSET AND DEATH
30 yrs | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (All stating the UNDERLYING CONDITION last.)
ASCUD | | (B) DUE TO
ASCUD | | 20 yrs | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
CON PLUMONARY | | | | 5 yrs | |
| 19A. DATE OF OPERATION
4/30/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/21/66 19 66 to 4/30 19 66 , that (I) (we) last saw the deceased alive on 4/30/66 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Edward A. Hoffman | | | | 23B. DATE SIGNED
4/30/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/2/1966 | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | 25B. NAME OF REGISTRAR
Wm. F. Fickner & Sons | | 25C. FUNERAL DIRECTOR
Baltimore, Md. | |

South Portland General Hospital

2-2-1940

W M

Plt. Mary E. Bryant

ASCOB

Cor. P. C. ...

4/1/40

4/1/40

4/1/40

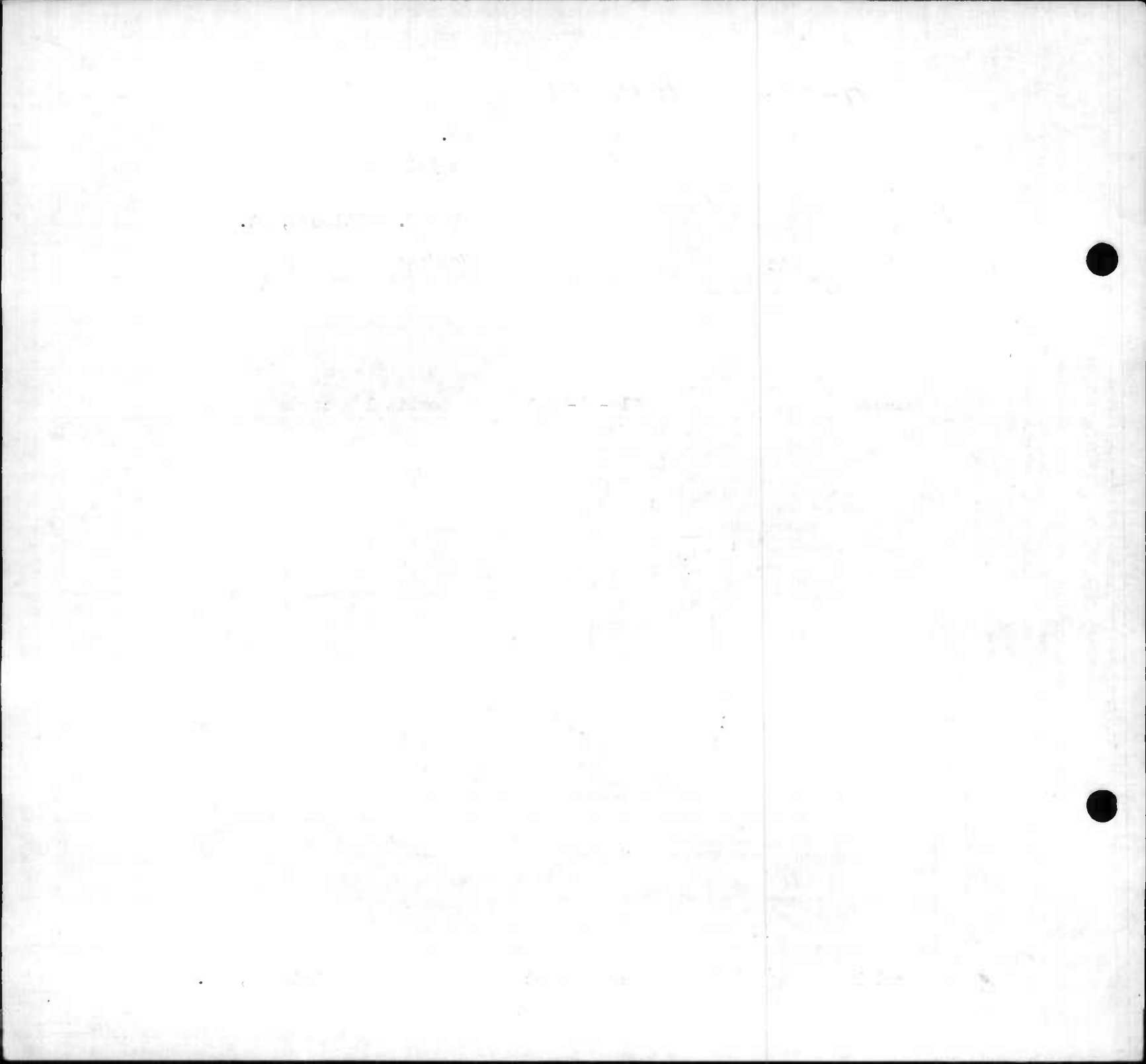
Edward A. ...

4/1/40

Released by Med. Examiner
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|---|---|--|
| BIRTH NO. 66 04433 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04433 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) ALFRED HEMLING | | 2. DATE AND HOUR OF DEATH
4-27-66 3:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 4-01 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
7 Mercy Hospital. | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location)
704 E. Baltimore St. | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
9/25/1899 | 9. AGE (In years last birthday)
66 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Unknown | | 16. SOCIAL SECURITY NO.
214-01-2107 | | 17. INFORMANT ADDRESS
Hospital Records | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
E916.0 | | | CAUSE OF DEATH
A. Sepsis
B. Burns 1st & 2nd degree
C. 15-20% Tissue Ant. & Post. | | INTERVAL BETWEEN ONSET AND DEATH
16 days |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT.
Relium Tremens | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Hotel | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
704 E. Balto. St. 4-01 | |
| 21D. TIME OF INJURY (APPROX.)
3 11 66 4:05 PM | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Conflagration | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-11-66 19 65 to 4-27 19 66 , that (I) (we) last saw the deceased alive on 4-27 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Leahella Y. Condon | | | | 23B. DATE SIGNED
4/27/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/30/66 | | 24C. NAME OF CEMETERY or CREMATORY
Sacred Heart | |
| 24D. LOCATION
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | | |
| 25B. NAME OF REGISTRAR
P. E. Seaberg, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
William J. Lickens & Sons North & Pa. Ave | | | |



1

BALTIMORE CITY HEALTH DEPARTMENT

66 04434

BIRTH NO.

66 04434

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)H. H.
William Hunt

2. DATE AND HOUR PRONOUNCED DEAD

Friday 4/29/66 6:30 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

905 West Lemmon Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

Aug. 20, 1917

9. AGE (in years
last birthday)

48

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Handy Man

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Lewis Co., W. Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Walter G. Hunt

14. MOTHER'S MAIDEN NAME

Ocie ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War II

16. SOCIAL
SECURITY NO.

232-09-2901

17. INFORMANT

Col. Jay Hunt

ADDRESS

503 South George St.

Charlestown, West Virginia

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Pneumococcal Pneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/30/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5/3/1966

23C. NAME OF CEMETERY or CREMATORY

Baltimore National Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 2 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Wm. J. Fickner & Sons Baltimore, Md.

0-43

100

1-1-1

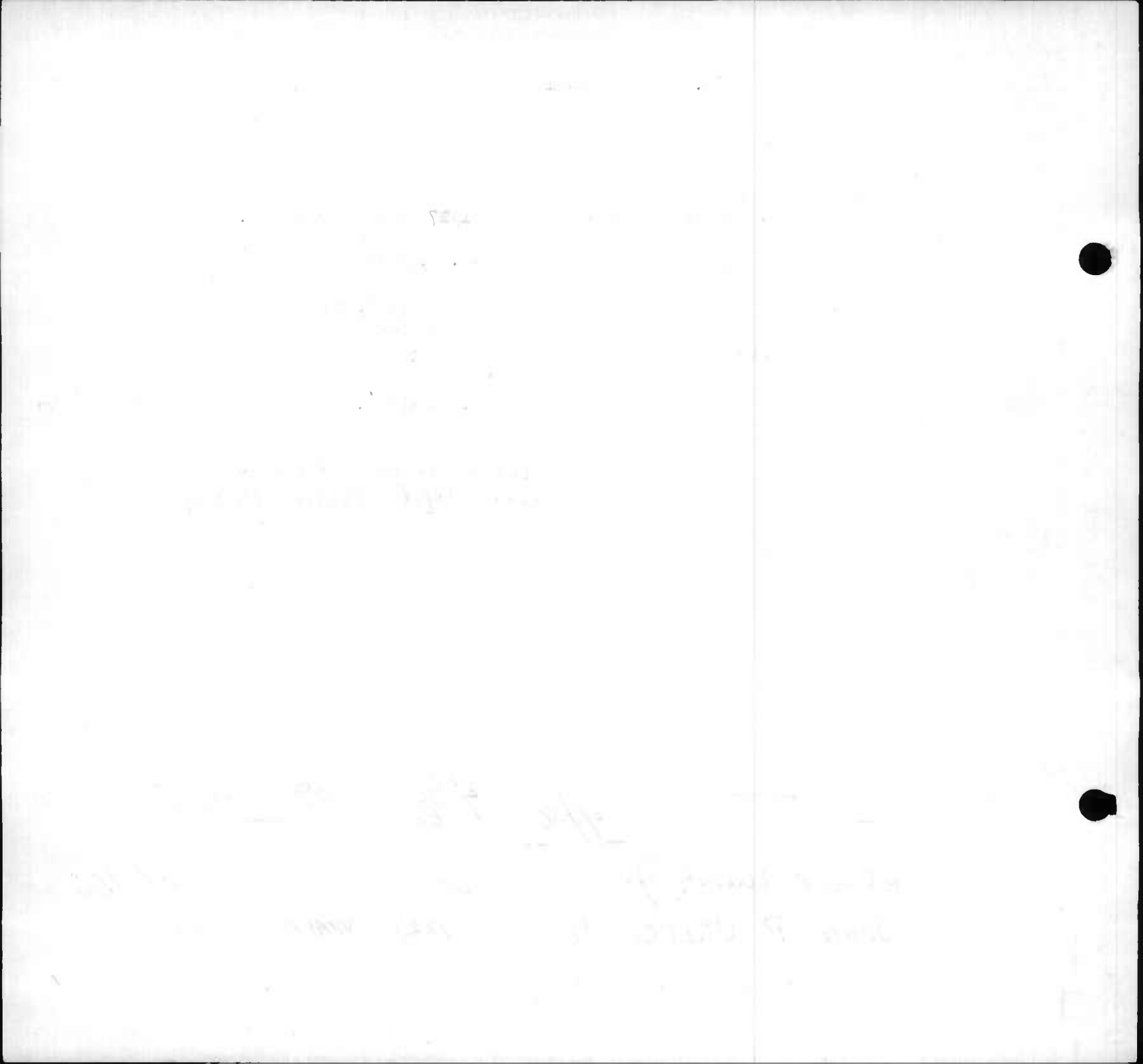
11/1/11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66-04435 | |
|---|------------------|---|-----------------------------------|---|---|--|------------------------------|
| M.E. CASE NO. 66-04435 | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Mary E. Ruppel | | | | 2. DATE AND HOUR OF DEATH
April 30, 1966 1 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1907 North Fulton Avenue
Baltimore, Maryland 21217 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 8. COUNTY
Maryland 15-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1907 North Fulton Ave. 17 | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
Aug. 6, 1879 | 9. AGE (In years last birthday)
86 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME
? Jackson | | | 14. MOTHER'S MAIDEN NAME
? | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mr. Albert J. Ruppel same address as above | | |
| 18. 142.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) DUE TO
Carcinoma basal cell left Parathyroid Gland
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
1-year | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/20 1959 to 4/30 1966, that (I) (we) last saw the deceased alive on 4/30 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
John P. Urlock Jr. | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
5/2/66 | |
| 23C. PHYSICIAN'S NAME (Type)
JOHN P. URLOCK JR. | | | | M.D. 23D. ADDRESS
122) WASH. BLVD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/3/1966 | | 24C. NAME of CEMETERY or CREMATORY
Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D. BY HEALTH DEPT.
MAY 2 1966 | | | | 25B. NAME OF REGISTRAR
Robert E. ... | | 25C. FUNERAL DIRECTOR ADDRESS
Wm. J. Tichner & Son Balto. Md. north 11th Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|---|--|---|---|--|--|--|--|
| 66 04436 | | | | | 66 04436 | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| BIRTH NO. | | | | | Registered No. | | | | |
| M.E. CASE NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED
(Type or Print) FESSLER, William ALBERT | | | | | 4/30/1966 4:10 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
44 UNION MEMORIAL | | | | | A. STATE
MARYLAND | | | | |
| | | | | | B. COUNTY
27-11 | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTO. MD. | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
100 W. COLD SPRING LA. | | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify) | | 8. DATE OF BIRTH
12/9/1996 | 9. AGE (In years last birthday)
66 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of week if retired)
Executive Fertilizer Co. | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Fertilizer Mfg. | | 11. BIRTHPLACE (State or foreign country)
NEW JERSEY | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
CHRISTIAN FESSLER | | | | | 14. MOTHER'S MAIDEN NAME
MARTHA GROSS | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
WIFE | | ADDRESS
S/A | |
| 18. 203X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | (A) Renal Failure - oliguria
DUE TO | | | | |
| | | | | | (B) Multiple myeloma
DUE TO | | | 7 years | |
| | | | | | (C) | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | Samuel J. Lloyd | |
| | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (H) (this hospital) attended the deceased from 4/26/66 to 4/30/66 that (H) (we) last saw the deceased alive on 4/30/66 and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Robert Whitlock | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/30/66 | | |
| 23C. PHYSICIAN'S NAME (Type)
ROBERT N. WHITLOCK | | | | | 23D. ADDRESS
UNION MEMORIAL HOSPITAL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/3/1966 | | 24C. NAME OF CEMETERY or CREMATORY
Druid Ridge Cemetery | | | 24D. LOCATION (City, town, or county) (State)
Pikesville, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | | 25C. FUNERAL DIRECTOR
Wm. J. Fickner & Sons | | | | |

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

66 04437

BALTIMORE CITY HEALTH DEPARTMENT

66 04437

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY

BARNES

2. DATE AND HOUR PRONOUNCED DEAD

May 1, 1966

3:00 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Silver Spring

D. STREET ADDRESS (If rural, give location)

215 Crestmore Circle

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

19

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Asphyxia due to Hanging.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Hospital

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

University Hospital

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
5 1 '66 A

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Hanged self.

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/1/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

CREMATION

23B. DATE

5-2-66

23C. NAME of CEMETERY or CREMATORY

LEE'S CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Washington, D.C.

24A. DATE REC'D BY HEALTH DEPT.

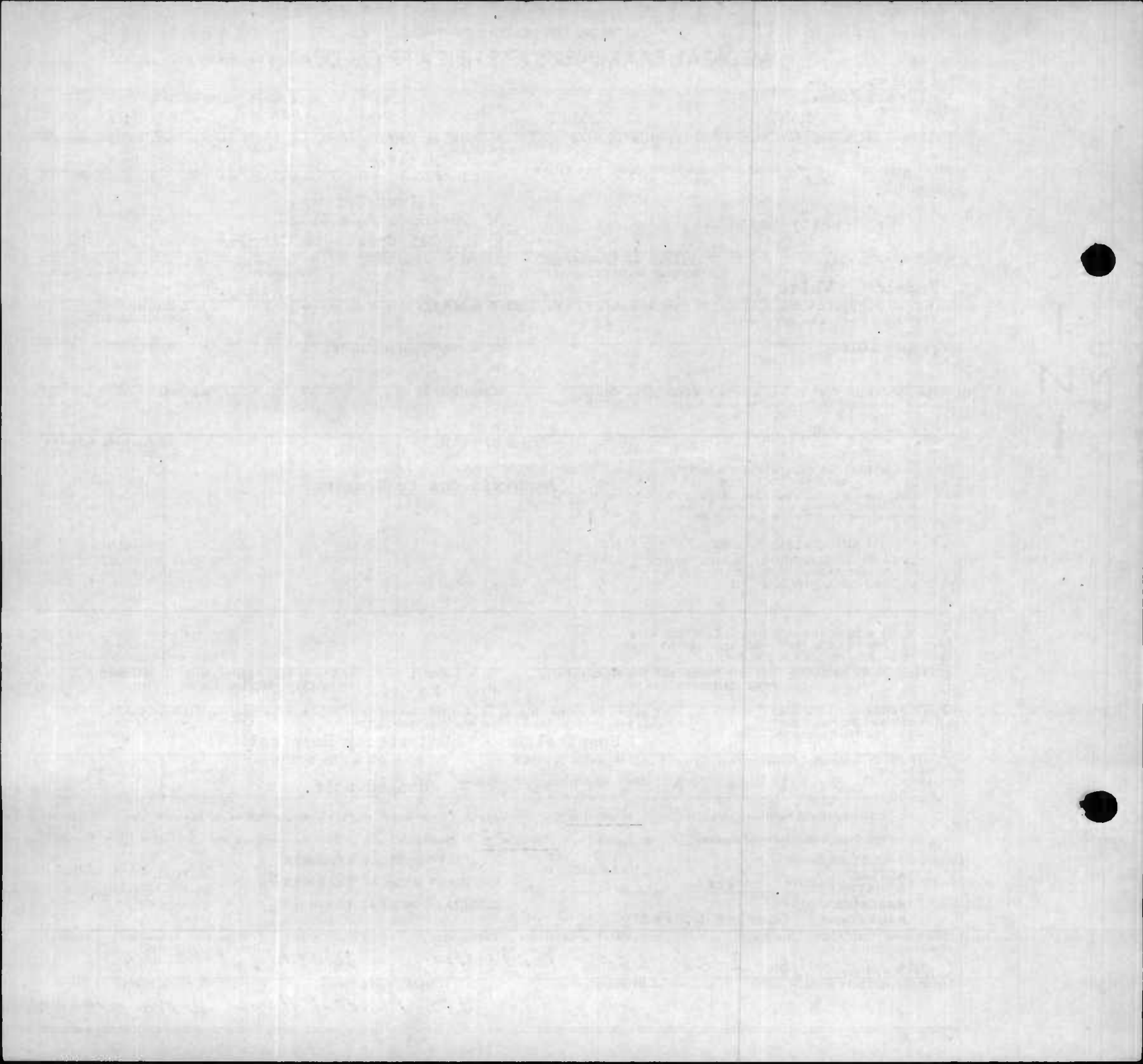
MAY 2 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

LEE FUNERAL HOME Washington, D.C.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04438 | |
|--|------------------|--|--|---|--|
| BIRTH NO. 66 04438 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JAMES P. Mitchell | | 2. DATE AND HOUR OF DEATH April 28, 1966 10⁰⁰ A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION MERCY Hospital | | A. STATE Md. | | B. COUNTY 5-02 | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 2 | | | |
| | | D. STREET ADDRESS (If rural, give location) 1043 HILLEN ST. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH 885 10/22/1885 | 9. AGE (In years last birthday) 80 | 10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Va | |
| 13. FATHER'S NAME James R. | | 14. MOTHER'S MAIDEN NAME Mary F. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 219-01-5501 | | 17. INFORMANT Vernon Richardson | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) bronchopneumonia, bilat | | 1 week | |
| ANTECEDENT CAUSES | | (B) emphysema | | at least 1 wk | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) ASCVD | | if | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from April 22, 1966 to April 28, 1966 , that (we) last saw the deceased alive on April 28, 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Wm Gregory Bruce M.D. | | | | 23B. DATE SIGNED April 28, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4/30/66 | | 24C. NAME OF CEMETERY OR CREMATORY Woodlawn | |
| 24D. LOCATION (City, town, or county) (State) Baltimore 7, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 2 1966 | | 25B. NAME OF REGISTRAR W. E. Johnson | | 25C. FUNERAL DIRECTOR Witzke ADDRESS F.D. 4101 E. Edmondson Ave | |

Letter from informant 5/1/62

Henry

Henry

Henry

1043 Miller St

1043 Miller St

1043 Miller St

Henry

X

April 28 1962

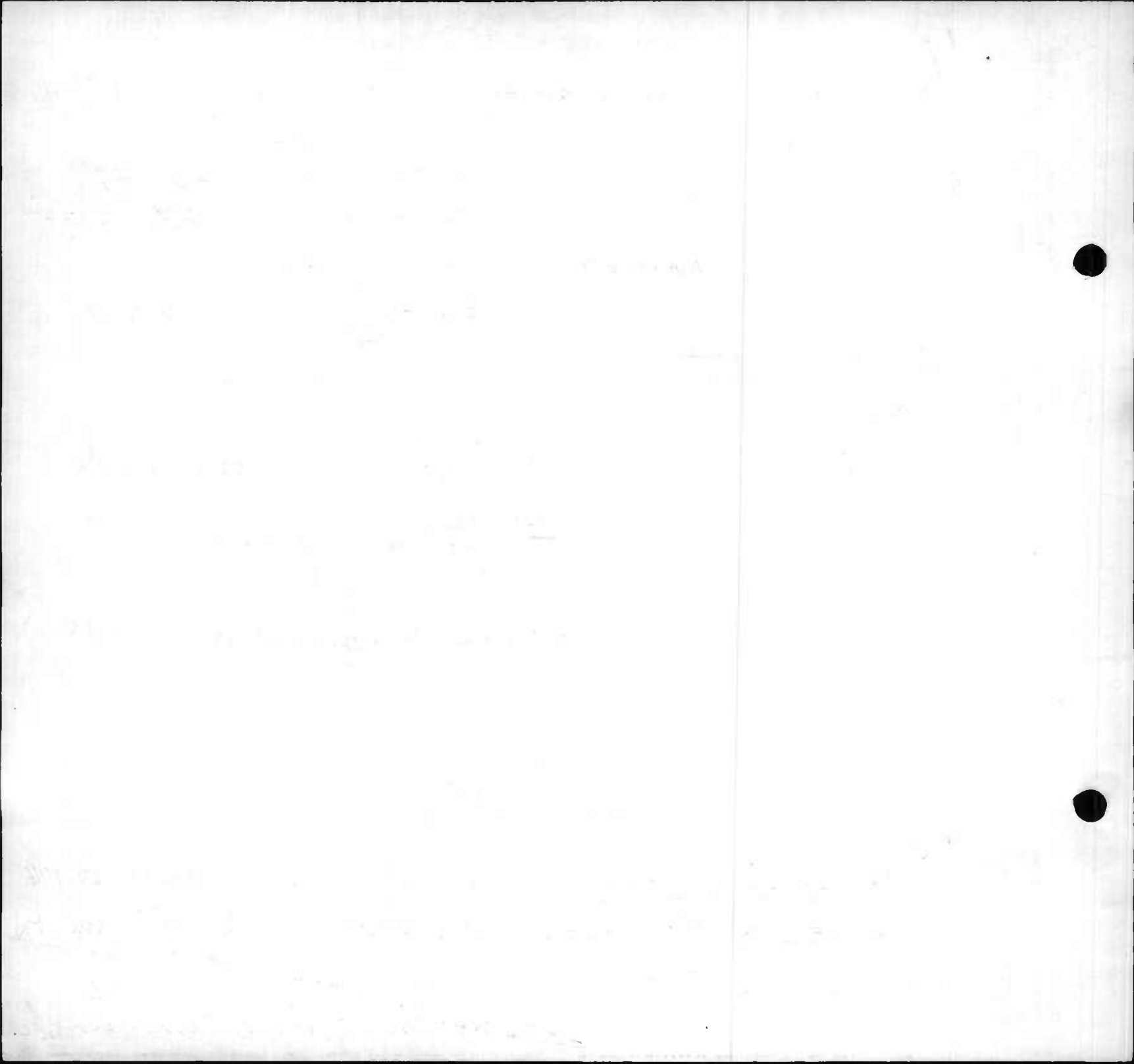
April 28 1962

April 28 1962

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------|--|------------------------|--|--|--|--|------------------------------|--|
| 66 04439 | | | | | 86 04439 | | | | |
| BIRTH NO. | | | | | REGISTERED NO. | | | | |
| M.E. CASE NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED
(Type or Print) ELIZABETH BLANCHE CRAWLEY | | | | | 4-29-66 11 20 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Bon Secours Hospital 2025 West Fayette | | | | | A. STATE B. COUNTY | | | | |
| | | | | | Principis Baltimore | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | 625 North BEND Road 29 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) | | | | |
| Baltimore Md 21229 | | | | | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days | | 11. Under 24 Hrs. Hours Min. | |
| Female | White | MARRIED | | ? | 80 | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | | | | Baltimore | | U.S.A. | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | |
| James Watt | | | | | ? | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | | | | | | | | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | CAUSE OF DEATH | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) Cerebral Thrombosis DUE TO | | | | |
| ANTECEDENT CAUSES | | | | | (B) ARTERIOSCLEROSIS CARDIOVASCULAR DISEASE | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (C) | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | ATRIAL FIBRILLATION | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April-26-1966 to April-29-1966, that (I) (we) last saw the deceased alive on April-29-1966, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED | |
| Angel S. Gonzalez | | | | | | | | April-29-1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS | | | | |
| ANGEL S. GONZALEZ | | | | | Bon Secours Hosp - Baltimore - Md | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 5/2/66 | | Lorraine Park | | Baltimore 7, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR | | | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| MAY 2 1966 | | | D. S. F. J. J. J. | | | Witke F. P. 4101 Edmondson Ave | | | |



1
13-400

66 04440 BALTIMORE CITY HEALTH DEPARTMENT 66 04440

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____ M.E. CASE NO. _____

| | | | |
|---|-----------------------------|---|--|
| 1. NAME OF DECEASED
(Type or Print) Willie Bell Bell | | 2. DATE AND HOUR PRONOUNCED DEAD
4/28/66 3:30 a. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
St. Agnes Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY _____
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 20-05
D. STREET ADDRESS (If rural, give location)
2523 Ashton St. | |
| 5. SEX
female | 6. RACE
white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
May 4, 1935 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
H.W. | | 10B. KIND OF BUSINESS OR INDUSTRY
Crown Home | |
| 13. FATHER'S NAME
Percy Bryant | | 14. MOTHER'S MAIDEN NAME
Rina Smith | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS
Nelson Bell - 2523 Ashton St. |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Fibrino-purulent peritonitis following gunshot wound of abdomen, involving liver and stomach
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
home | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
2523 Ashton St. |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
4 1 66 8:40p.m. | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21F. HOW DID INJURY OCCUR?
shot following argument |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE Werner U. Spitz
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.
DATE SIGNED 4/28/66 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 23B. DATE
4/30/66 | 23C. NAME OF CEMETERY or CREMATORY
Crest Lawn | 23D. LOCATION (City, town, or county) (State)
Md. |
| 24A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | 24B. NAME OF REGISTRAR
W. E. Johnson | 24C. FUNERAL DIRECTOR ADDRESS
W. E. Johnson 4101 Edmondson |

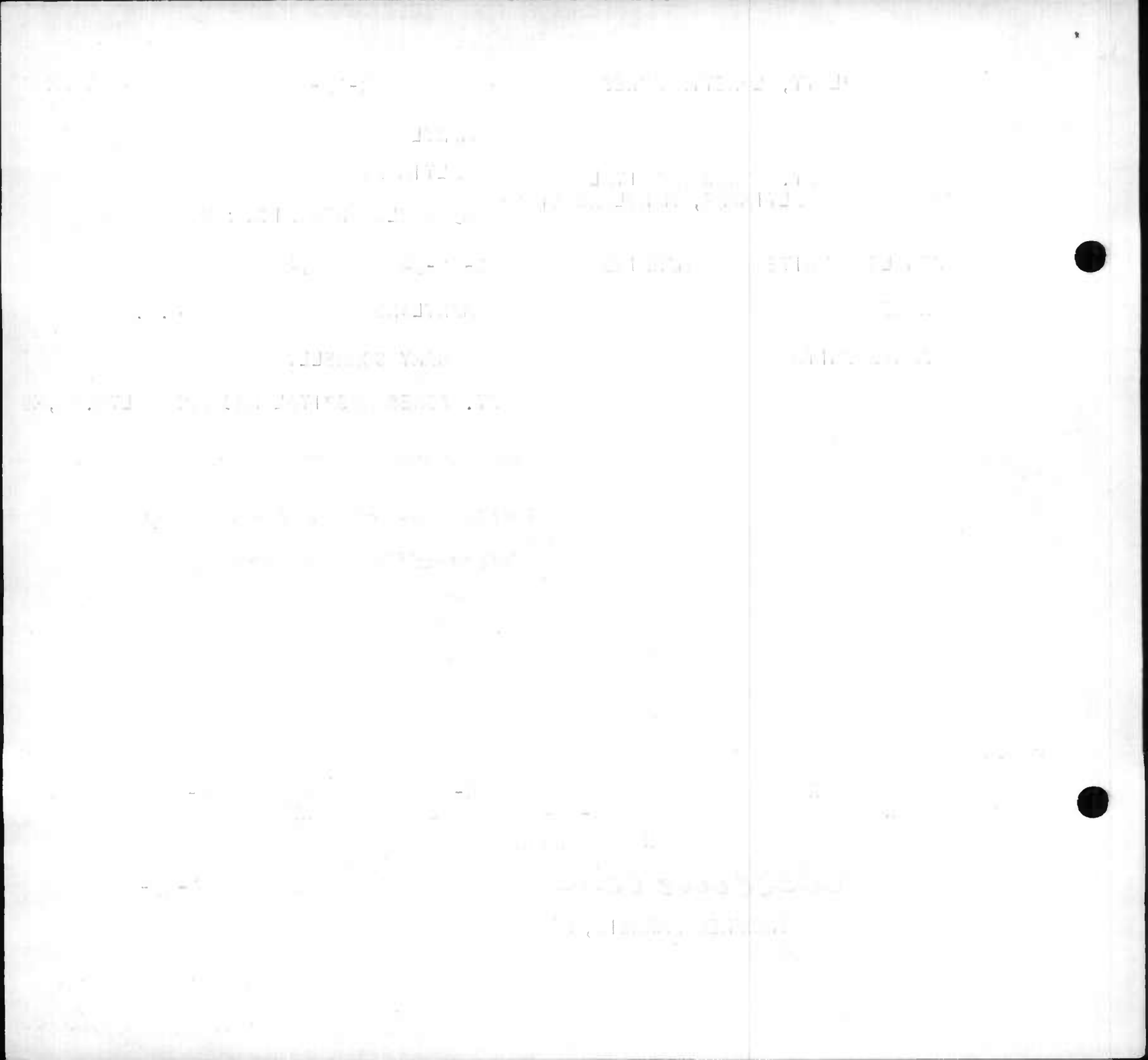
VS 151-REV. 1/1/65

940 20N7-47

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------|--|-----------------------------------|--|--|--|-----------------------------|------------------------------|----------------------------------|
| 66 04441 | | | | | Registered No. 66 04441 | | | | |
| BIRTH NO. | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED
(Type or Print) PLATT, LORETTA AGNES | | | | | 4-29-66 4 AM M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | A. STATE B. COUNTY | | | | |
| ST. AGNES HOSPITAL
BALTIMORE, MARYLAND 21229 | | | | | MARYLAND | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | |
| | | | | | BALTIMORE | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) | | | | |
| | | | | | 4500 OLD FREDERICK ROAD | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| FEMALE | WHITE | MARRIED | 2-22-93 | 73 | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| NONE | | | | | | MARYLAND | | U.S. | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | |
| JAMES SMITH | | | | | MARY CONNELLY | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| | | | | | ST. AGNES HOSPITAL RECORDS BALTO. 29, MD | | | | |
| 18. 331X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH
(A) DUE TO
CEREBRAL HEMORRHAGE
(B) DUE TO
ARTERIAL HYPERTENSION
(C) DUE TO
ARTHEROSCLEROSIS | | | | INTERVAL BETWEEN ONSET AND DEATH |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 0 | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | | | | | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from 4-29-66 to 4-29-66, that (X) (we) last saw the deceased alive on 4-29-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Manfred Amrhein | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4-29-66 | | |
| 23C. PHYSICIAN'S NAME (Type)
MANFRED AMRHEIN, MD | | | | | 23D. ADDRESS | | | | |
| | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 5-2-66 | | Landon Park | | Baltimore, 29, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| MAY 2 1966 | | Robert S. F... | | Witke, P.D. - 4101 | | Cumberland Cr. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | Registered No. 66 04442 |
|--|--------------|--|-----------------------------------|---|--|--|
| 66 04442 | | | | | | CERTIFICATE OF DEATH |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH |
| | | | | John Robert Mainhart | | 4-30-66 5:50A. M. |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | | A. STATE | | B. COUNTY |
| South Baltimore General Hosp. | | | | Maryland | | 44 |
| | | | | C. CITY OR TOWN (outside city limits, write RURAL and give township) | | |
| | | | | Glen Burnie | | 32-00 |
| | | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | | 602 Binsted Rd. | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| M | White | Married | 10-31-25 | 40 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Branch Manager | | | Banking | | Frederick Maryland | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | | 12. CITIZEN OF WHAT COUNTRY? |
| Lester Mainhart | | | Rebecca Morsell | | | U.S.A. |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | WWTT 219-20-1903 | | Georgeanna K. Mainhart 602 Binsted Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | |
| | | | | (A) Generalized Carcinomatosis
DUE TO
1° unknown. | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | |
| | | | | (C) | | |
| II | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 2 | | | | Yes | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| | | | | | | |
| 22. I certify that at (this hospital) attended the deceased from 4-22 19 66 to 4-30 19 66 , that we (we) last saw the deceased alive on 4-30 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | |
| Hugh J. Hargrave | | | | 4-30-66 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | |
| | | | | South Balto. General Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) |
| Burial | | 5-2-1966 | | Lake View Memorial | | Carroll Co., Md. |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS |
| MAY 2 1966 | | Robert E. Fisher | | Living Byers | | 8728 Liberty Road Randallstown, Md. |

4-30-40

4-30-40

Robert V. Lindhart

Maryland

Glen Burnie

South Baltimore General Hosp. Corbinstead Rd.

Mr White Marnie 10-31-22 40

Maryland

Ellen

Reester

Yes

4-30-40

4-30-40

4-30-40

4-30-40

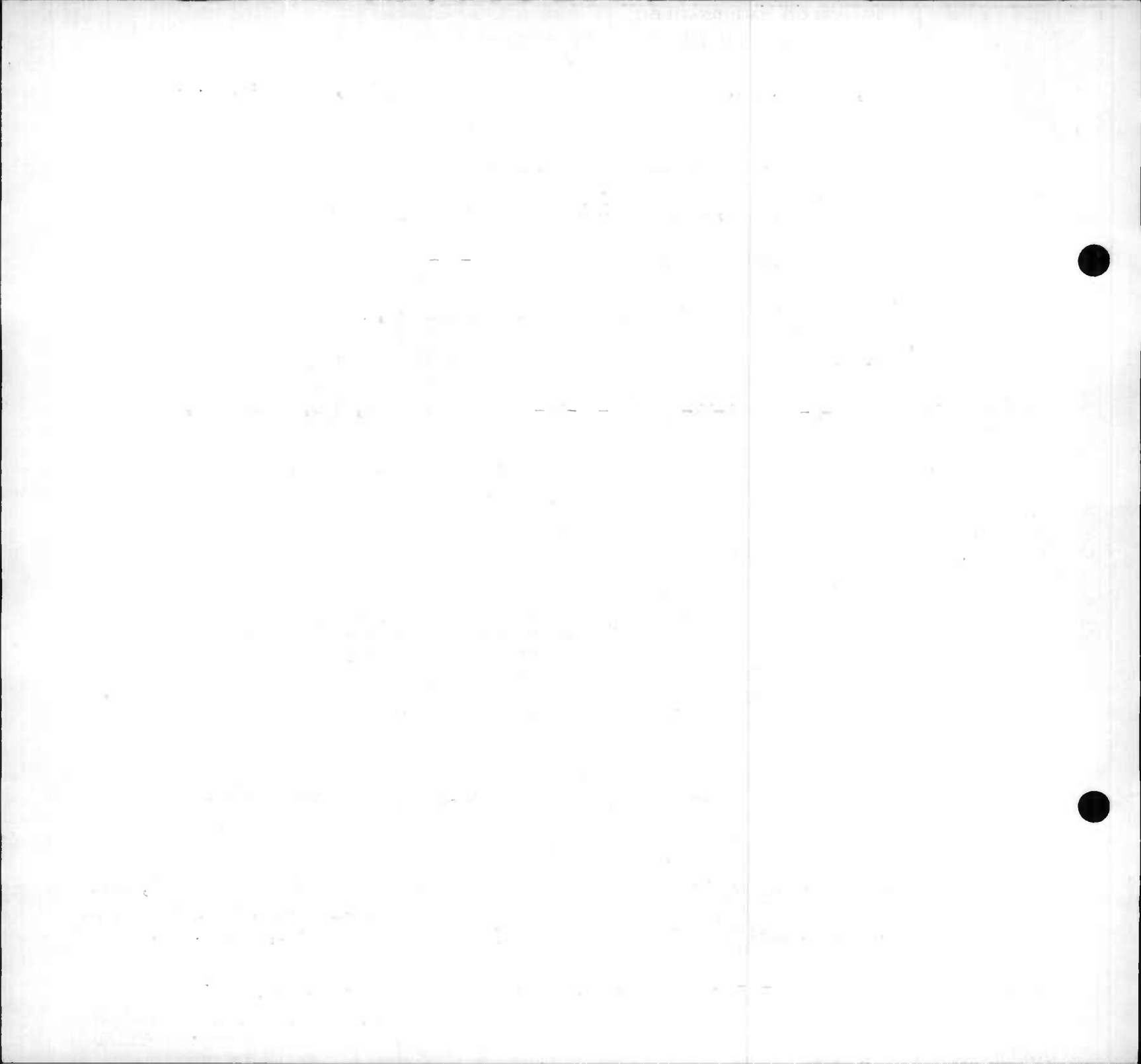
4-30-40

✓

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

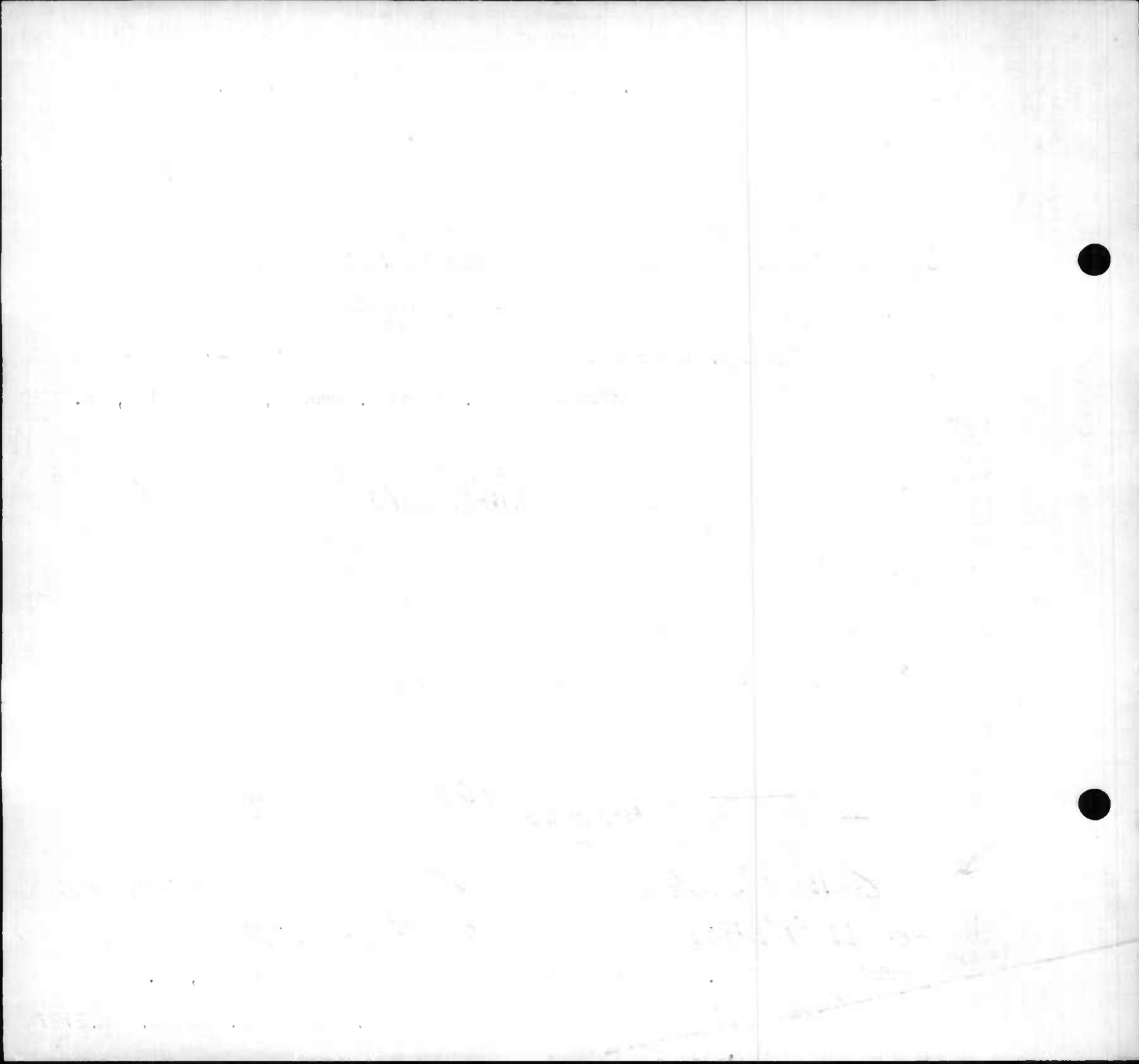
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04443 | |
|---|-----------------------------|--|------------------------------------|--|--|
| BIRTH NO. 66 04443 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) LOBER, FRED J. JR. | | | |
| 2. DATE AND HOUR OF DEATH
MAY 1, 1966 5:17 P.M. | | M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
VETERANS ADMINISTRATION HOSPITAL
3900 LOCH RAVEN BLVD.
BALTIMORE, MARYLAND 21218 | | A. STATE MARYLAND B. COUNTY BALTIMORE | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location)
2607 KINGSRIDGE ROAD | | | |
| 5. SEX
MALE | 6. RACE
CAUCASION | 7. MARRIED, NEVER MARRIED
MARRIED | 8. DATE OF BIRTH
9-15-15 | 9. AGE (In years last birthday)
50 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
THEATER MANAGER | | 10B. KIND OF BUSINESS OR INDUSTRY
MOVIE PICTURE HOUSE | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
FRED J. LOBER | | | |
| 14. MOTHER'S MAIDEN NAME
UNKNOWN Anna Gallagher | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES 2-3-41 to 2-22-45 | | | |
| 16. SOCIAL SECURITY NO.
216-01-29-81 | | 17. INFORMANT ADDRESS
CLIN RECORDS, VAH, BALTIMORE, MARYLAND | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)
CHRONIC OBSTRUCTIVE PULMONARY DUE TO EMPHYSEMA | | INTERVAL BETWEEN ONSET AND DEATH
10 YEARS | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | (C) DUE TO | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 19 19 66 to MAY 1 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAY 1 19 66 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
James W. Keller | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
MAY 1, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
JAMES W. KELLER | | 23D. ADDRESS
VETERANS ADMINISTRATION HOSPITAL
3900 LOCH RAVEN BLVD., BALTO. MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5-5-66 | | 24C. NAME OF CEMETERY or CREMATORY
BALTIMORE NATIONAL Cemetery | |
| 24D. LOCATION
BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | | |
| 25B. NAME OF REGISTRAR
LEONARD J. RUCK INC | | 25C. FUNERAL DIRECTOR ADDRESS
5305 HARFORD RD BALTO. MARYLAND | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

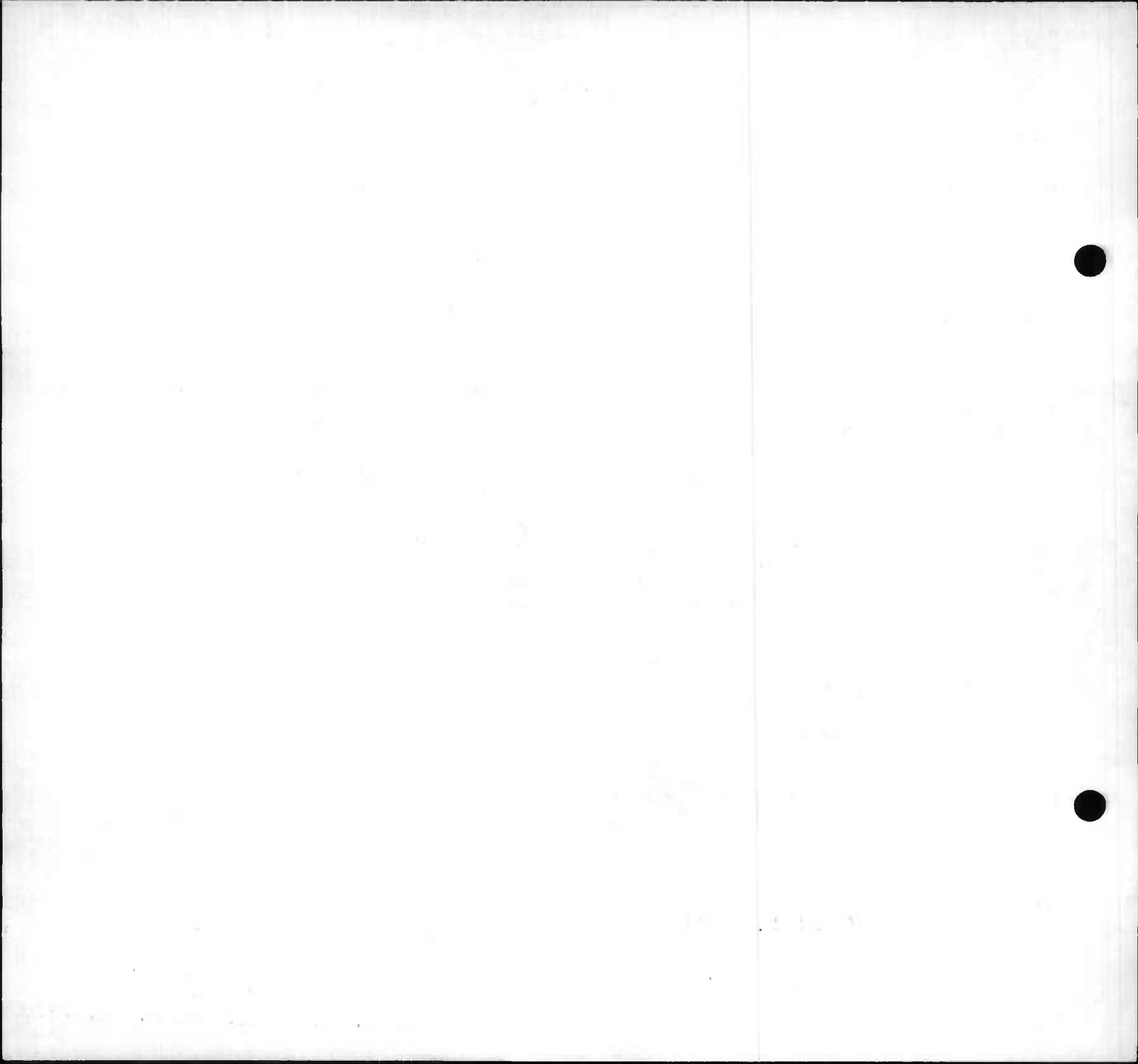
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04444 |
|---|-----------------------------|---|---|---|
| BIRTH NO. 66 04444 | | CERTIFICATE OF DEATH | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Elizabeth G. Brennan | | April 30, 1966. 4 A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
5502 Kemper Road | | A. STATE Md. B. COUNTY 27-12 | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore #10 | | |
| | | D. STREET ADDRESS (If rural, give location)
5502 Kemper Road | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
July 6, 1892 | 9. AGE (In years last birthday)
73 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
David J. Williamson | | |
| 14. MOTHER'S MAIDEN NAME
Sarah J. Keith | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | |
| 16. SOCIAL SECURITY NO.
212-50-6306 | | 17. INFORMANT ADDRESS
Mr. George K. Brennan, 5510 Boxhill, La. 21210 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Carcinoma of liver (Hobnail) | | INTERVAL BETWEEN ONSET AND DEATH
2 years | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | |
| 19A. DATE OF OPERATION
9-24-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Removal of hernia | | 20A. AUTOPSY? (Yes or No)
No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (the hospital) attended the deceased from 1960 19 to 4-30-66 19, that (I) (we) last saw the deceased alive on 4-27-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
G. W. Peake M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED
4-30-66 |
| 23C. PHYSICIAN'S NAME (Type)
G. W. PEAKE | | 23D. ADDRESS
M.D. 4508 Hayford Road Balto 14, Md | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
5/3/66. | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | 25B. NAME OF REGISTRAR
E. E. ... | | 25C. FUNERAL DIRECTOR ADDRESS
Leonard J. Ruck Inc. Balto. Md. 21214 |



FUNERAL DIRECTOR: IMPORTANT

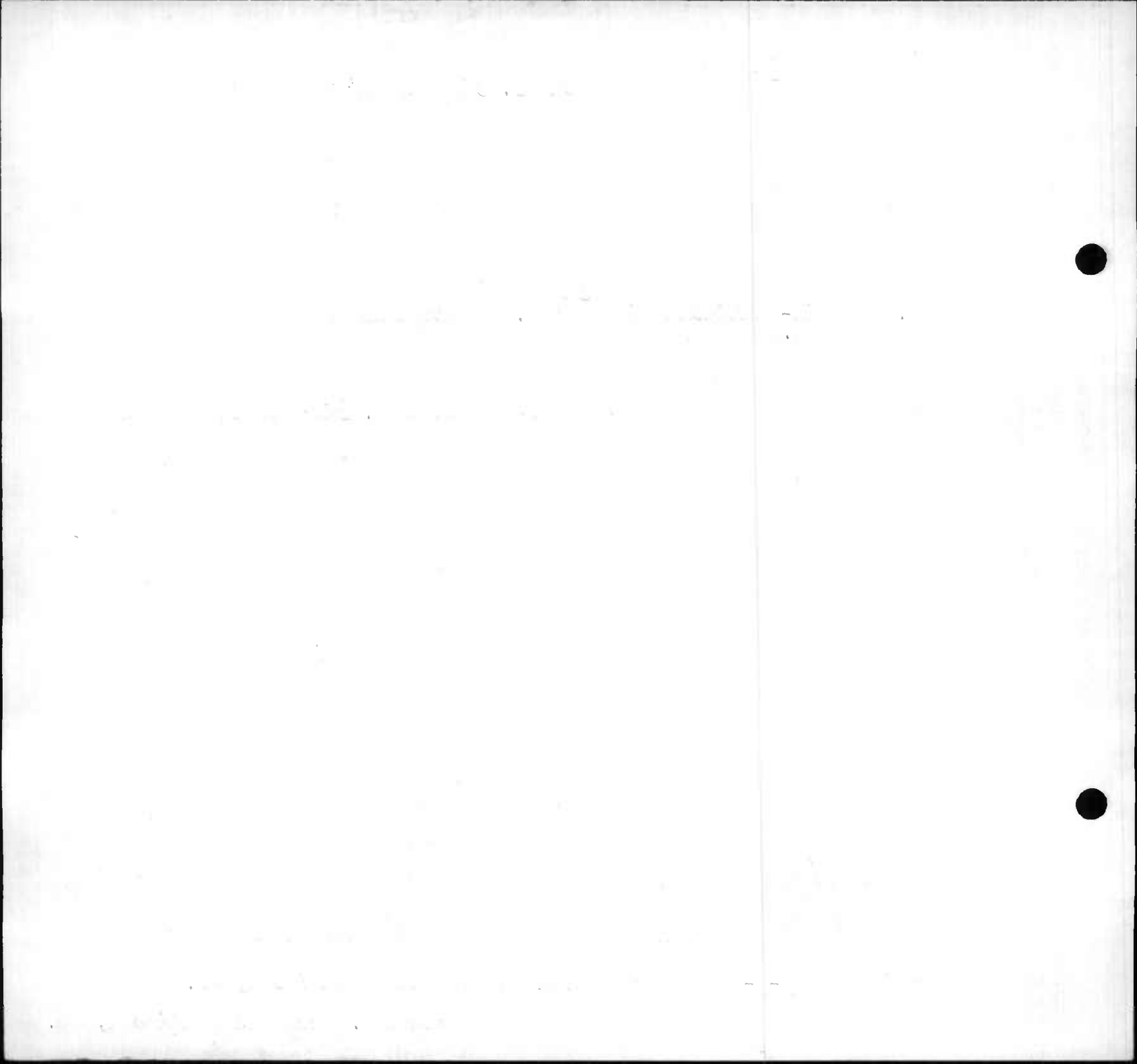
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04445 | |
|---|--------------|--|----------------------------|---|---|
| CERTIFICATE OF DEATH | | | | | |
| MIRTH NO.
M.E. CASE NO. | | 66 04445 | | | |
| 1. NAME OF DECEASED
(Type or Print) | | MEIFARTH, LOIS (NMN) | | 2. DATE AND HOUR OF DEATH
4/30/66 12 ³⁵ P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY
MD. 906 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
UNION MEMORIAL HOSP | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location)
1613 E 30 TH ST | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
W | 8. DATE OF BIRTH
6/4/89 | 9. AGE (In years last birthday)
76 | 10. If Under 1 Yr. Months; Days; If Under 24 Hrs. Hours; Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
— | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MD | |
| 12. CITIZEN OF WHAT COUNTRY?
US | | 13. FATHER'S NAME
JOSEPH RILEY (D) | | 14. MOTHER'S MAIDEN NAME
ELIZABETH MOORE (D) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
MRS. LOIS LAMBDIN BALTO MD 21234
2908 EMERALD RD. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
58111
CAUSE OF DEATH
(A) Hepatic failure
(B) haemorrhagic Anemia
(C) —
INTERVAL BETWEEN ONSET AND DEATH
— | | 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
4/25/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
ASCITES | | 20A. AUTOPSY? (Yes or No)
YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
— | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
— | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
— | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)
— | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
— | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/18/1960 to 4/30/1966, that (I) (we) last saw the deceased alive on 4/30/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Charles S. Brown | | | | 23B. DATE SIGNED
4/30/66 | |
| 23C. PHYSICIAN'S NAME
CHARLES S. BROWN | | | | 23D. ADDRESS
M.D. UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/3/66 | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | | |
| 25B. NAME OF REGISTRAR
R. E. Fisher | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck Inc. Balto. | | 25D. ADDRESS
Md. 21214 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 66 04446 | |
|---|----------------------|---|--|--|---|--|--|--|--|--|--|
| BIRTH NO. 66 04446 | | CERTIFICATE OF DEATH | | | | | | Registered No. 66 04446 | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>John Fitzgerald</i> | | | | | | 2. DATE AND HOUR OF DEATH <i>4/28/66</i> <i>1140 P</i> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i> | | A. STATE <i>MARYLAND</i> B. COUNTY <i>HARFORD</i> | | | | | | | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>JOPPA</i> | | | | | | | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>908 MAGNOLIA ROAD</i> | | | | | | | | | |
| 5. SEX <i>MALE</i> | 6. RACE <i>WHITE</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i> | | 8. DATE OF BIRTH <i>7-17-96</i> | 9. AGE (In years last birthday) <i>69</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Captain-Baltimore City Dept.</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>fire</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | |
| 13. FATHER'S NAME <i>JOHN FITZGERALD</i> | | | | 14. MOTHER'S MAIDEN NAME <i>JOHANNA MALONE</i> | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | | | 16. SOCIAL SECURITY NO. <i>217481421</i> | | 17. INFORMANT <i>Bertha S. Fitzgerald</i> | | ADDRESS <i>same</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO <i>Cardiac Arrest</i> | | | | <i>Yes.</i> | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO <i>Myocardial infarction</i> | | | | <i>2 days</i> | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) <i>ASCVD</i> | | | | <i>1 year</i> | | | |
| II | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION <i>4-20-66</i> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <i>he</i> (this hospital) attended the deceased from <i>4/26/66</i> <i>1966</i> to <i>4/28/66</i> <i>1966</i> that <i>he</i> (we) last saw the deceased alive on <i>4/28/66</i> <i>1966</i> and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>(We)</i> (We) (did) <i>(did not)</i> view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <i>W. H. Spencer III</i> | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>4/28/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>W. H. Spencer III</i> | | | | | | | | 23D. ADDRESS <i>Johns Hopkins Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i> | | | | 24B. DATE <i>5-3-66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i> | | 24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i> | | (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAY 2 1966</i> | | | | 25B. NAME OF REGISTRAR <i>P. E. Taylor, M.D.</i> | | | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc Baltimore, Md.</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66-04447 | |
|--|------------------|---|-----------------------------|---|---|
| BIRTH NO.
66-04447 | | CERTIFICATE OF DEATH | | 2. DATE AND HOUR OF DEATH
5-1-66 4:45 AM. | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print)
ENEY, VERNON, EDWARD | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
ST. AGNES HOSPITAL | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE #14 | | D. STREET ADDRESS (If rural, give location)
4911 MORELLO RD. | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
1-14-01 | 9. AGE (In years last birthday)
65 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Printer | | 10B. KIND OF BUSINESS OR INDUSTRY
Newspapers | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
EDWARD Eney | | 14. MOTHER'S MAIDEN NAME
VIOLA DIXON | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
215-10-8723A | | 17. INFORMANT
ST. AGNES HOSPITAL
CATON & WILKENS AVE. 21229 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
DISEASE OR CONDITION
420.1 I
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DUE TO
Myocardial Infarction
(B) DUE TO
ASCVD
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
2 days
10-12 yrs | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Severe CHF, ileus | | 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-28 1966 to 5-1-1966, that (I) (we) last saw the deceased alive on 5-1-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
DR. PHILIP J. WHELAN | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
5/1/66 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. PHILIP J. WHELAN | | 23D. ADDRESS
ST. AGNES HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/4/66. | | 24C. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | | |
| 25B. NAME OF REGISTRAR
Charles E. Taylor | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck Inc. Balto. Md. 21214 | | ADDRESS | |

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66 04448

BALTIMORE CITY HEALTH DEPARTMENT

66 04448

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EARL K. CLARK

2. DATE AND HOUR PRONOUNCED DEAD

April 30, 1966 10:12 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland Balto.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore #20

D. STREET ADDRESS (If rural, give location)

31 Stabilizer Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Nov. 24, 1904.

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Machine Operator

10B. KIND OF BUSINESS OR INDUSTRY

Blach & Decker

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John D. Clark

14. MOTHER'S MAIDEN NAME

Clara J. Drew

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-09-8385

17. INFORMANT

Mrs. Magdalene L. Clark

ADDRESS

(Same)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple Traumatic Injuries.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Road

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Stabilizer Dr. & Yawmeter Dr.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
4 30 '66 A

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Driver of auto into fixed object.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/1/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5/4/66.

23C. NAME of CEMETERY or CREMATORY

Parkwood Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 2 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck Inc. Balto. Md. 21214

WVA 11 FEB 1960

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10/10

Nov. 20, 1904

Nov. 20, 1904

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Nov. 20, 1904

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Nov. 20, 1904

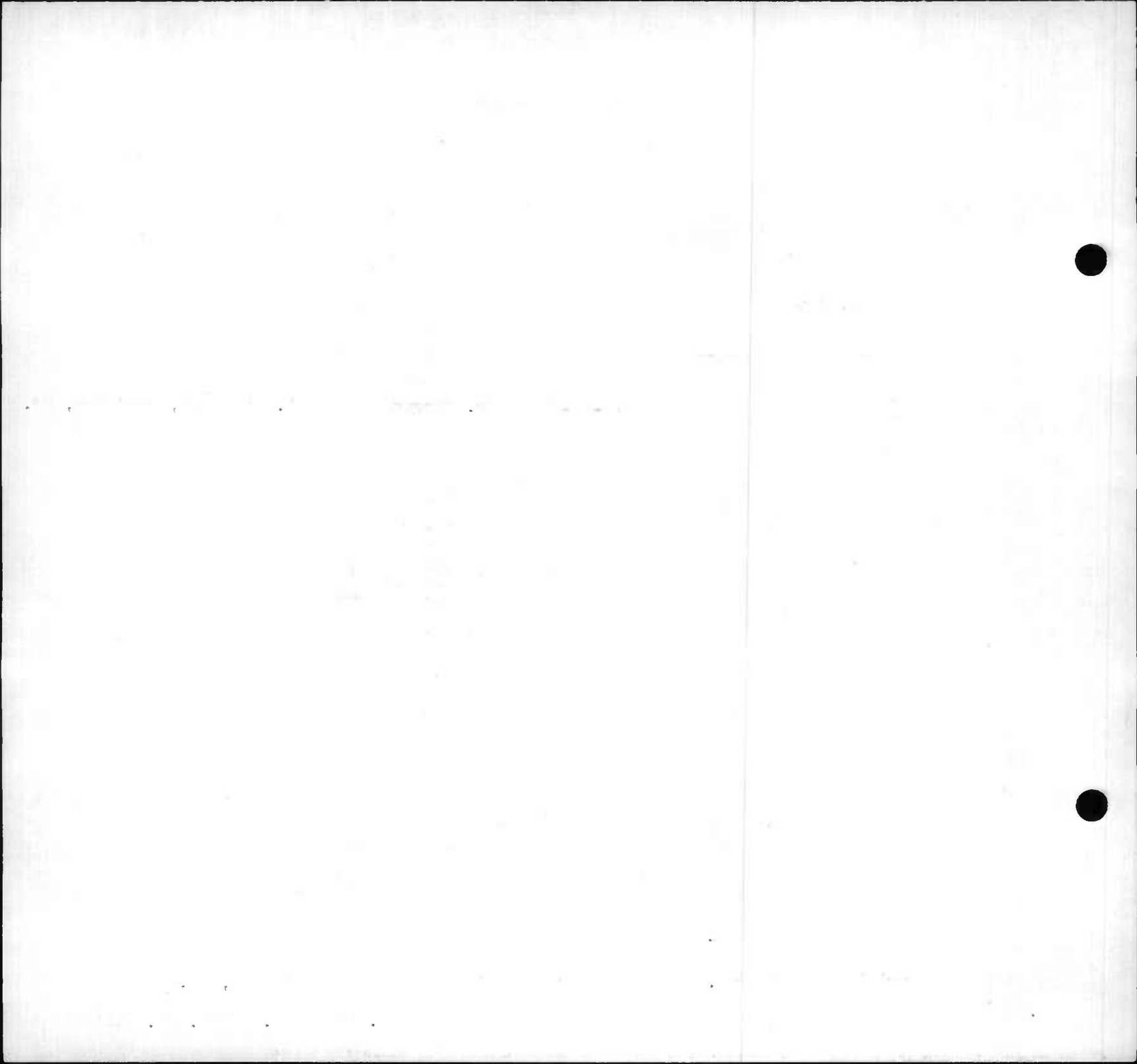
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 04449 | |
|--|------------------|---|-----------------------------------|---|--|--|--|
| BIRTH NO.
66 04449 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) ANNA C. SARGUS | | 2. DATE AND HOUR OF DEATH
APRIL 30, 1966 6:40 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
BON SECOURS HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 27-09
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
1530 NORTH BOURNE RD. (21212) | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
12/25, 1885 | 9. AGE (In years last birthday)
80 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
BEIRUT, LEBANON | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
JOSEPH CONRY (Khoury) | | | | 14. MOTHER'S MAIDEN NAME
LILA HABIB | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
217-48-8245 | | 17. INFORMANT
Fr. Sargus | | ADDRESS
St. Stephens, Bradshaw, Md. | |
| 18. 422.11
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

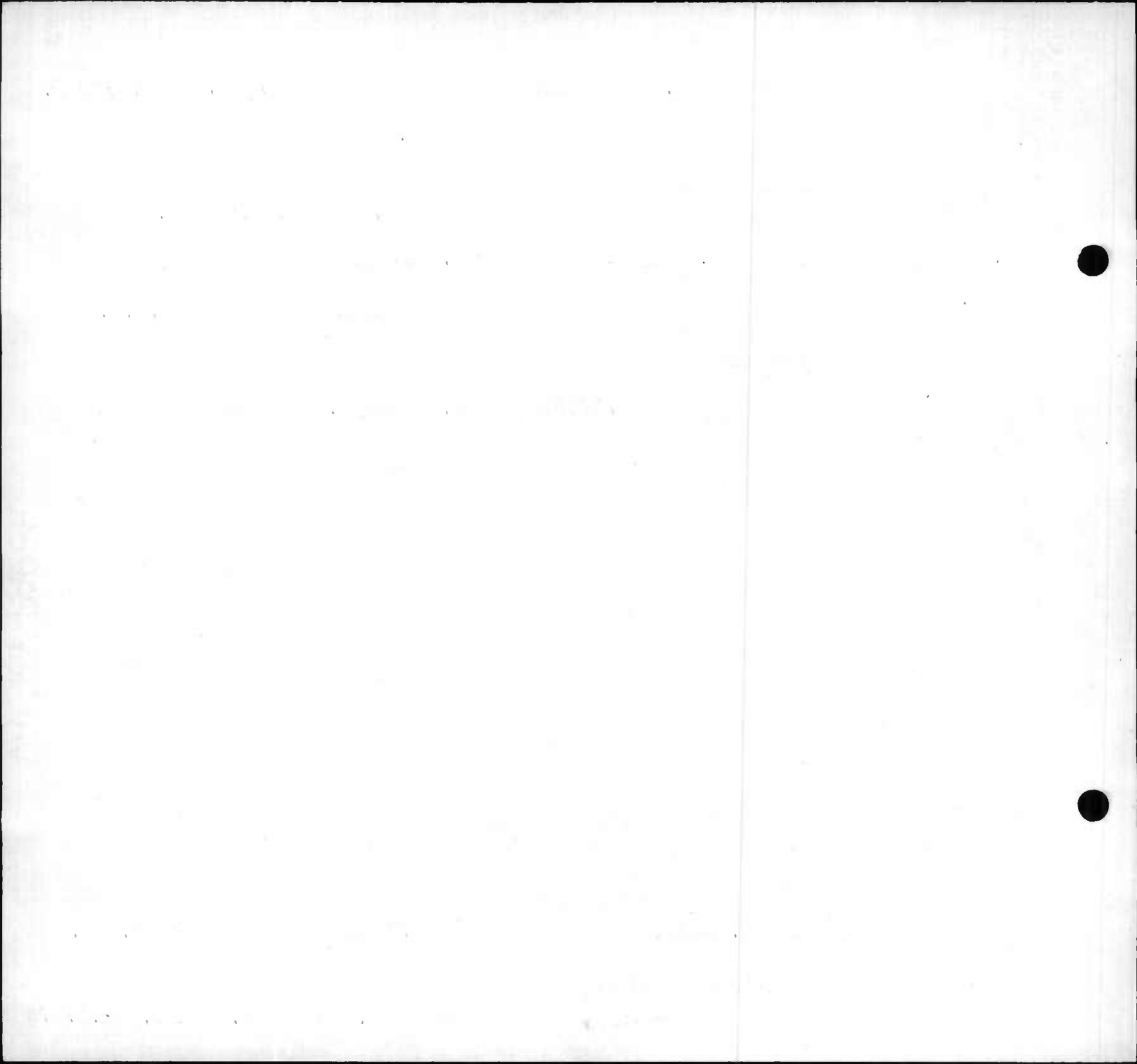
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) CAROPO PULMONARY FAILURE Years
DUE TO
(B) ATHEROSCLEROTIC CARDIO VASCULAR DISEASE Years
DUE TO
(C) | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
GASTROENTERITIS | | | | | | DAYS | |
| 19A. DATE OF OPERATION
APRIL 14/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
BILATERAL CATARACT | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 11 19 66 to April 30 19 66, that (I) (we) last saw the deceased alive on April 30 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Joe V. de Leon, Jr. | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
April 30, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
JOSE V. DE LEON, JR. | | | | 23D. ADDRESS
M.D. Bon Secours Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/3/66. | | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | 25B. NAME OF REGISTRAR
R. E. Farley | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck Inc. Balto. Md. 21214 | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04450 | |
|--|-------------------------|--|---|--|--|
| BIRTH NO. 66 04450 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Robert H. Spangler | | 2. DATE AND HOUR OF DEATH
April 30, 1966. 10:20 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 27-09 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
Union Memorial Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location)
1223 Sheridan Ave. | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
Mar. 2, 1898 | 9. AGE (In years)
lost birthday
68 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Ambrose Spangler | | 14. MOTHER'S MAIDEN NAME
? | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
212108694 | | 17. INFORMANT
Mrs. Agnes R. Spangler | |
| | | | | ADDRESS
Same | |
| 18. 163 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
Carcinoma of Lung | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
? | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
N/O | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 1965 to 19 , that (I) (we) last saw the deceased alive on 1 month ago 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
George H. Beck | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
5/2/66 | |
| 23C. PHYSICIAN'S NAME (Type)
George H. Beck, | | 23D. ADDRESS
M.D. 6012 Harford Road, Balto., Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/4/66 | | 24C. NAME OF CEMETERY or CREMATORY
Parkwood Cemetery | |
| | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | 25B. NAME OF REGISTRAR
Leonard J. Ruck Inc. | | 25C. FUNERAL DIRECTOR
Balto. Md. 21214 | |

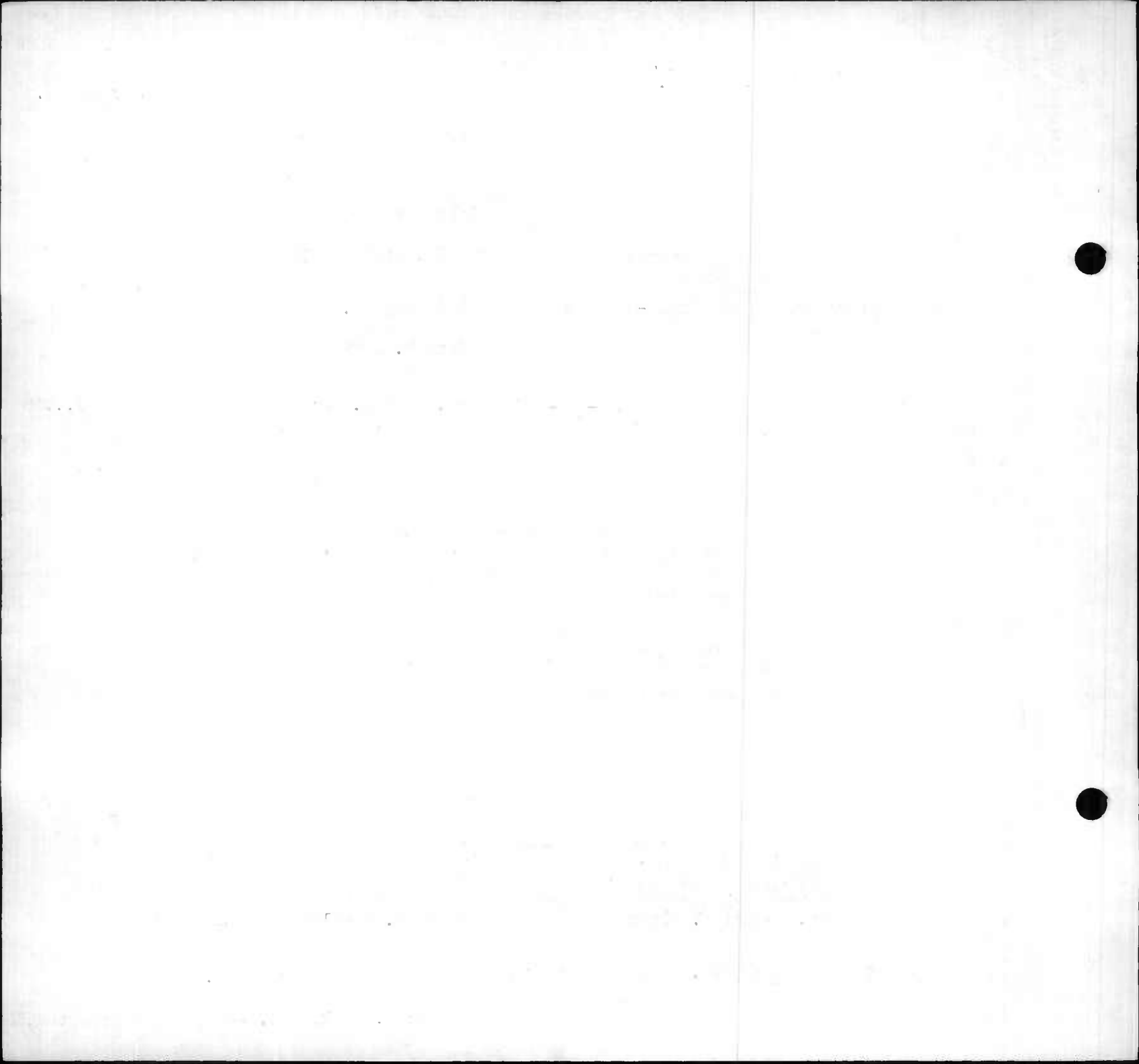


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------|---|---|----------------------------------|--|---------------------------------|--|---|--|
| 66 04451
CERTIFICATE OF DEATH | | | | | Registered No. 66 04451 | | | | |
| BIRTH NO. 66 04451 | | | | | M.E. CASE NO. 7. | | | | |
| 1. NAME OF DECEASED
(Type or Print) Dr. John S. Hall | | | | | 2. DATE AND HOUR OF DEATH
April 30, 1966 12:30 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give sheet address or location)
1619 Ralworth Road | | | | | A. STATE
Maryland | | | | |
| | | | | | B. COUNTY
none | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore #18 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
1619 Ralworth Road | | | | |
| 5. SEX
male | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | | 8. DATE OF BIRTH
May 31, 1893 | 9. AGE (In years last birthday)
72 | 10. Under 1 Yr.
Months: Days | | 11. Under 24 Hrs.
Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
dentist: retired | | | 10B. KIND OF BUSINESS OR INDUSTRY
self-employed | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Charles Hall | | | | | 14. MOTHER'S MAIDEN NAME
Jane R. Gardner | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
212-40-7224 | | 17. INFORMANT ADDRESS
Mrs. John S. Hall, 1619 Ralworth Road, ..18 | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH
(A) DUE TO
Coronary Thrombosis | | | INTERVAL BETWEEN ONSET AND DEATH
Instant | |
| | | | | | (B) DUE TO
Gen. Arteriosclerosis ? | | | | |
| | | | | | (C) DUE TO
Blocking Peptic Ulcer | | | 3 mos | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
O | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-28-1963 to 4-30-1966, that (I) (we) lost saw the deceased alive on 4-30-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 12:30 A.M. | | | | | | | | | |
| 23A. SIGNATURE
Robert H. Siver | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
5-2-66 | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Robert H. Siver | | | | | 23D. ADDRESS
3105 N. Charles Street, Baltimore | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
burial | | | 24B. DATE
5/3/66. | | 24C. NAME OF CEMETERY or CREMATORY
Greenmount Cemetery | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | | 25B. NAME OF REGISTRAR
Robert E. Siver | | 25C. FUNERAL DIRECTOR ADDRESS
Leonard J. Ruck, Inc. -- 5305 Harford Road, 14 | | | | |



Released on Approval - 4-30-66
ST. LOUIS
B-6220
FURNAL DIRECTOR: IMPORTANT
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

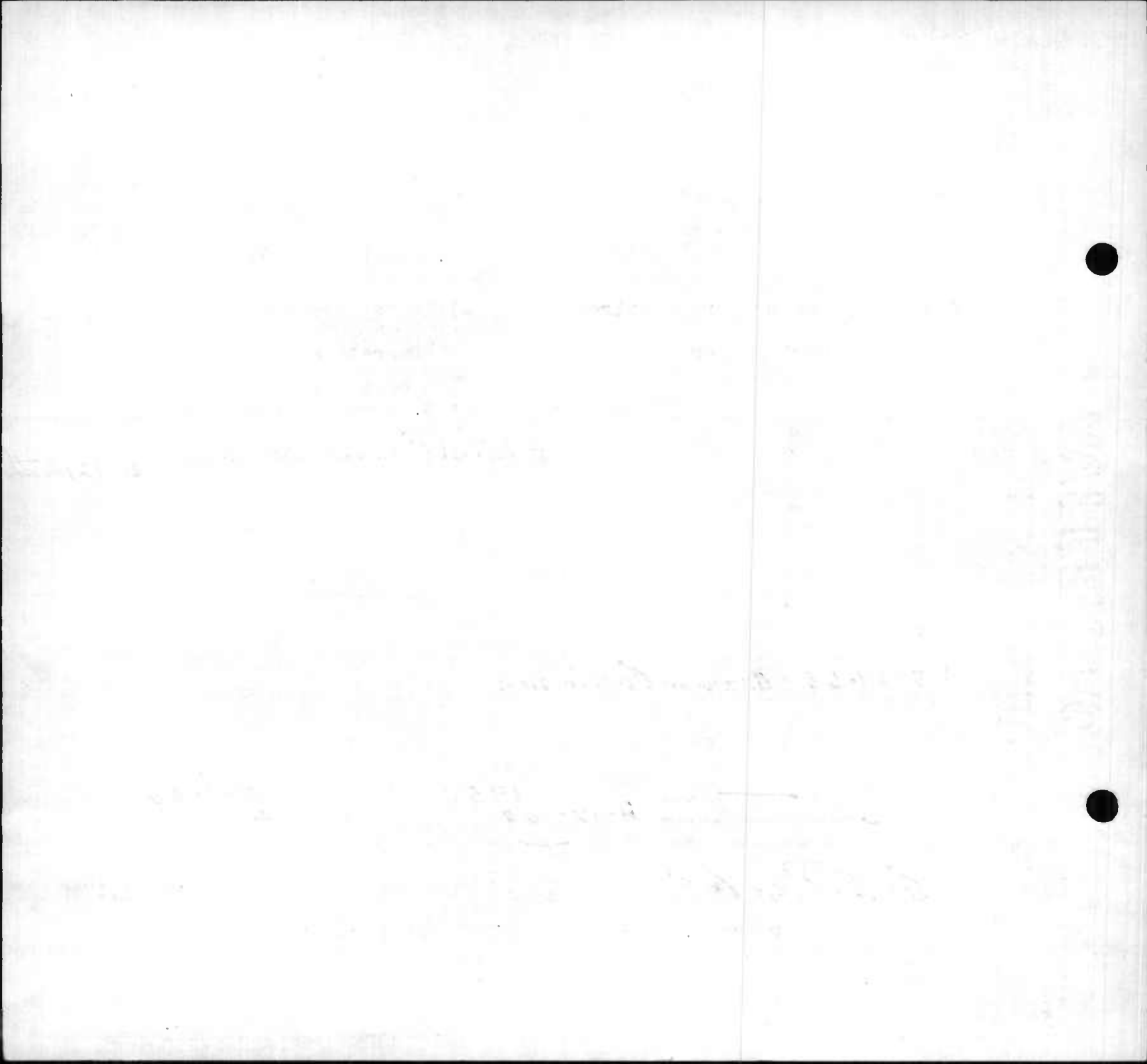
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04452 | |
|--|---------|--|------------------|--|-----------------------------|
| BIRTH NO. | | | | M.E. CASE NO. 66 04452 | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Fannie Bell Bowers | | 4-30-66 - 6:35 PM M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Union Memorial Hosp | | MD DEPT. 27-01 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 5837 Belair Rd. Baltimore | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| F | Ca | Widowed | 9-1-72 | 93 | 24 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | MD | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Jacob Thompson | | UAK | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | None | | Robert W. Beery 4809 Waltham Blvd. G. Johnson | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | 19. CAUSE OF DEATH, EXAMINED BY CHIEF OF MEDICAL EXAMINER | | INTERVAL BETWEEN ONSET AND DEATH | |
| E903.71 | | Pneumonia | | 2 days | |
| 20. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 21. Fx @ hip | | 6 days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 22A. DATE OF OPERATION | | 22B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 4-26-66 | | Fx @ hip | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | Nursing home | | 5837 Belair Rd 26-01 | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| Apr 24 66 | | While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | played while getting out of unknown | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-25-66 to 4-30-66 and that (I) (we) last saw the deceased alive on 4-30-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| E F Shaw Wilgis | | | | 4-30-66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| E F SHAW WILGIS | | | | UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | |
| Burial | | | | May 8, 1966 | |
| 24C. NAME OF CEMETERY or CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | |
| Westminster Cemetery | | | | Westminster, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | |
| MAY 2 1966 | | | | Leonard J. Ruck, Inc. -- 5305 Harford Rd, 14 | |

UNITED STATES OF AMERICA

2017 JAN 2

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04453 | |
|--|---------------------|---|---|--|--|
| BIRTH NO. 66 04453 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) EDNA MAER COSBY | | 2. DATE AND HOUR OF DEATH
MAY 1, 1966 1:15 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00 4626 Harcourt Road | | A. STATE Maryland
B. COUNTY 27-01 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 21214 | | | |
| | | D. STREET ADDRESS (If rural, give location)
4626 Harcourt Road | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOW | 8. DATE OF BIRTH
SEPT. 16, 1888 | 9. AGE (In years last birthday)
77 | (If Under 1 Yr. Months: Days: Hours: Min.) |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk Dry Goods Store | | 10B. KIND OF BUSINESS OR INDUSTRY
Retired | | 11. BIRTHPLACE (State or foreign country)
Baltimore Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Frederick Maer | | 14. MOTHER'S MAIDEN NAME
Margaret Haegen | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
213 18 2030 A | | 17. INFORMANT ADDRESS
4626 Harcourt Road
Mrs G. Leonard Vanlentine | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
Bilateral Ovarian Carcinoma | | CAUSE OF DEATH
(A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
6-12 Months | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
3-24-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Ovarian Carcinoma | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from 1950 19 to 5-1-66 19, that (I) (was) last saw the deceased alive on 4-12-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Clarence W. Peake | | | | 23B. DATE SIGNED
May 2, 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
Clarence W. Peake | | 23D. ADDRESS
4508 Harford Road | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/May/1966 | | 24C. NAME OF CEMETERY or CREMATORY
Woodlawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Woodlawn Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | 25B. NAME OF REGISTRAR
Henry Sander & Sons Inc. | | 25C. FUNERAL DIRECTOR ADDRESS
BALTIMORE, MARYLAND 21213 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>66 04454</u> | |
|---|---------------------|--|---|--|---|---|---|
| BIRTH NO. <u>66 04454</u> | | | | M.E. CASE NO. <u>66 04454</u> | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Robert Lee Harvey</u> | | | | 2. DATE AND HOUR OF DEATH
<u>4/29/66</u> <u>12:30 P.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>University of Maryland Hosp</u> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>225 N. Carrollton</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>N</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>Never married</u> | 8. DATE OF BIRTH
<u>3/31/1911</u> | | 9. AGE (In years last birthday)
<u>55</u> | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>machine operator</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Steel</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Georgia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> |
| 13. FATHER'S NAME
<u>Grady Harvey</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Sallie Harvey</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>217-05 1656</u> | | 17. INFORMANT
<u>Rt. James Harvey</u> | | ADDRESS
<u>225 N. Carrollton Ave.</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>Malignant Lymphoma (?)</u> | | | | CAUSE OF DEATH
(A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | |
| (C) DUE TO | | | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/12</u> 19 <u>66</u> to <u>4/29</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/29</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>William C. Wimmer</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>4/29/66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>William C. Wimmer</u> | | | | 23D. ADDRESS
<u>University Hosp</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>5-3-66</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Mt. Calvary Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Anne Arundel Co., Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 2 1966</u> | | 25B. NAME OF REGISTRAR
<u>R. E. F. F.</u> | | 25C. FUNERAL DIRECTOR
<u>Randolph J. Collick</u> | | ADDRESS
<u>2431 E. Oliver St.</u> | |

66 04455

BALTIMORE CITY HEALTH DEPARTMENT

66 04455

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Garrett D. Jones

2. DATE AND HOUR PRONOUNCED DEAD

4/28/66 1:23 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

733 School St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

733 School St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married

8. DATE OF BIRTH

8-15-96

9. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Gertrude Jones 2026 McCulloh St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A).....
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE
m. WORK AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/28/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5-4-66

23C. NAME OF CEMETERY or CREMATORY

Balto. Nat'l Cem.

23D. LOCATION

(City, town, or county)

(State)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 2 1966

George Nelson 1348 Calhoun St.

VALLEY FORD

240 SOUTH ST.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04456 | |
|---|-------------------------|--|---------------------------------|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 66 04456 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Green, Carrie Marie</u> | | 2. DATE AND HOUR OF DEATH
<u>10:15 PM</u> <u>4/28/66</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>University Hospital</u> | | A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>1388 W. North Ave</u> | | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>Negro</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Widow</u> | 8. DATE OF BIRTH
<u>1897</u> | 9. AGE (In years last birthday)
<u>69</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
— | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>Brooks, ?</u> | | 14. MOTHER'S MAIDEN NAME
<u>Lavinia Dawson</u> | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
— | | 17. INFORMANT
<u>Mary Clark - daughter</u> | |
| 18. <u>203X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <u>Spinal Chord damage</u>
<u>metastatic lesion to</u>
<u>spinal column</u>
(B) DUE TO
(C) — | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 days</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>4/25/66</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>chord compression</u> | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<u>NO</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
— | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
— | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/26</u> 19 <u>66</u> to <u>4/28</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/25</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>B. Ann Ward</u> | | | | 23B. DATE SIGNED
<u>4/28/66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
— | | | | 23D. ADDRESS
— | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>5-3-66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Mt. Auburn Cemetery</u> | |
| 24D. LOCATION
<u>Balto.</u> | | <u>Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 2 1966</u> | | 25B. NAME OF REGISTRAR
<u>Paul E. ...</u> | | 25C. FUNERAL DIRECTOR
<u>George Nelson</u> | |
| | | | | ADDRESS
<u>1348 Calhoun St.</u> | |

8/29/66 - Multiple Myeloma - autopsy report
from University Hosp - see file Anderson
Beds - Bur. of Statistics - R

BIRTH NO.

66 04457

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Joseph Parker

2. DATE AND HOUR PRONOUNCED DEAD

4/30/66 2:30 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Unit Block of Pearl St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1620 Riggs Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
single

8. DATE OF BIRTH

9-3-43

9. AGE (In years
last birthday)

23

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF
WHAT COUNTRY?
.U.S.A.

13. FATHER'S NAME

Fred Parker

14. MOTHER'S MAIDEN NAME

Hanna Alston

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Fred Parker 1620 Riggs Avenue

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Air embolism
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Stab wound of neck, involving jugular vein
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?
yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

627 Forney St. - rear

21D TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
4 30 66 2:20 a.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

stabbed in neck

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S

NAME (Type) Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/30/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5-3-66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

Balto.

(City, town, or county)

Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 2 1966

E. Taylor

G. G. Kelson 1348 Calhoun St.

WALTER H. FORTGE

RECEIVED

1911

1911

1911

1911

1911

1

66 04458

BALTIMORE CITY HEALTH DEPARTMENT

66 04458

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Herman Wilson

2. DATE AND HOUR PRONOUNCED DEAD

4/28/66 7:05 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

843 Pierce St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

843 Pierce St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married

8. DATE OF BIRTH

10-24-97

9. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Levi Wilson

14. MOTHER'S MAIDEN NAME

Louise Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

217-05-5866

17. INFORMANT

A

ADDRESS

Helena Wilson 2304 Tioga Pkwy.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/29/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5-2-66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

(City, town, or county)

Balto.

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 2 1966

24B. NAME OF REGISTRAR

Robert E. Fahn

24C. FUNERAL DIRECTOR

George Nelson

ADDRESS

1348 Calhoun St.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|--|--|
| W-452 66 04459 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04459 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Williams, Jacob H. | |
| 2. DATE AND HOUR OF DEATH
4/22/66 3 P.M. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Ave.
BALTIMORE MARYLAND 21224 | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 20-02 | | 5. SEX male 6. RACE Negro 7. MARRIED NEVER MARRIED WIDOWED DIVORCED (specify) | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | 8. DATE OF BIRTH
3/27/99 67 | | 9. AGE (In years last birthday) 67 | |
| D. STREET ADDRESS (If rural, give location)
2630 LAURETTA AVENUE | | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Porter | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Maryland Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Wesley H. WILLIAMS | |
| 14. MOTHER'S MAIDEN NAME
Margaret F. Dade | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
RECORDS: BCH 4940 EASTERN AVE., Balto. Md. 21224
+ Family | | ADDRESS | | | |
| 18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH
(A) Respiratory failure
DUE TO
(B) bilateral pneumonia 48 hrs
DUE TO
(C) Anorexia weakness
probable carcinoma metastasis
Pagets disease bone 2 years | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/6 1965 to 4/22 1966, that (I) (we) last saw the deceased alive on 4/22 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
James Sam Louie | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/22/66 | |
| 23C. PHYSICIAN'S NAME (Type)
JAMES SAM LOUIE | | 23D. ADDRESS
4940 EASTERN AVE., BALTO. MD. 21224
Baltimore City Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
April 28, 1966 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cemetery | |
| 24D. LOCATION
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Williams | | 25C. FUNERAL DIRECTOR
Robert E. Williams, 1701-03 N. Bond St. City 31213 | | | |

1872

1873

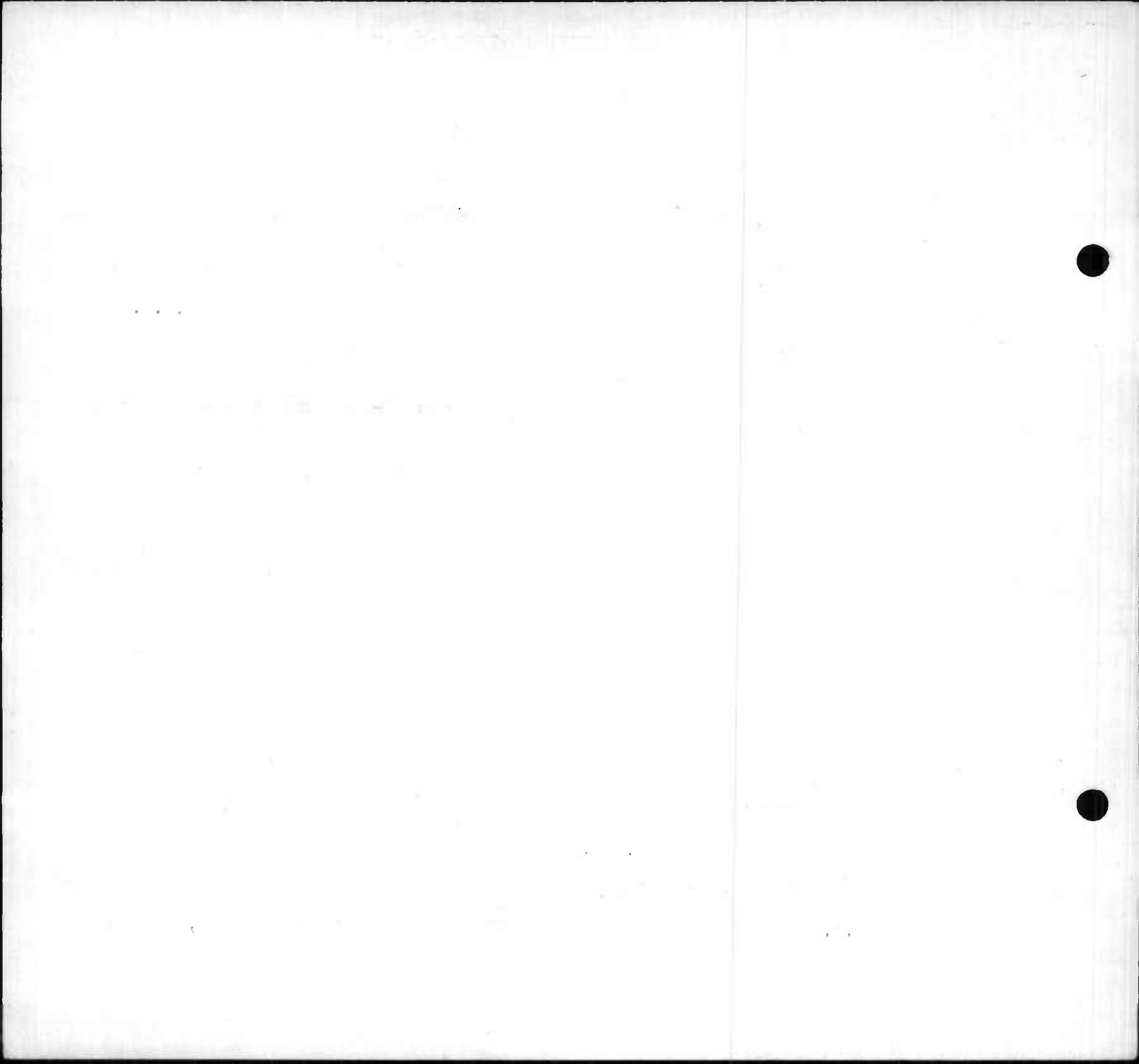
1874

1875

1876

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04460 | |
|--|--|--|--|--|--|
| BIRTH NO. 66 04460 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) EDNA WASHINGTON PAGE | | 2. DATE AND HOUR OF DEATH
1045 PM 4/20/66 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY 7-05 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| 5. SEX Female | | 6. RACE Negro | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Widowed | |
| 8. DATE OF BIRTH ? | | 9. AGE (In years last birthday) 66 | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
William Fleming | | 14. MOTHER'S MAIDEN NAME
Elizabeth Blake | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Records: BCH-4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) CARDIORESPIRATORY APPROPRIATE
(B) CONGESTIVE HEART FAILURE YEARS
(C) AORTIC INSUFFICIENCY YEARS | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/18/66 19 to 4/20/66 19 that (I) (we) last saw the deceased alive on 4/20/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
S.D. Kreider | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/20/66 | |
| 23C. PHYSICIAN'S NAME (Type)
S.D. Kreider | | 23D. ADDRESS
M.D. 4940 Eastern Avenue, Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Apr. 26, 1966 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Calvary Cemetery | |
| 24D. LOCATION
A.A. County, Md. | | 24E. STATE (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | 25B. NAME OF REGISTRAR
Robert E. Williams | | 25C. FUNERAL DIRECTOR
ADDRESS
1701-03 N. Bond St. 21213 | |

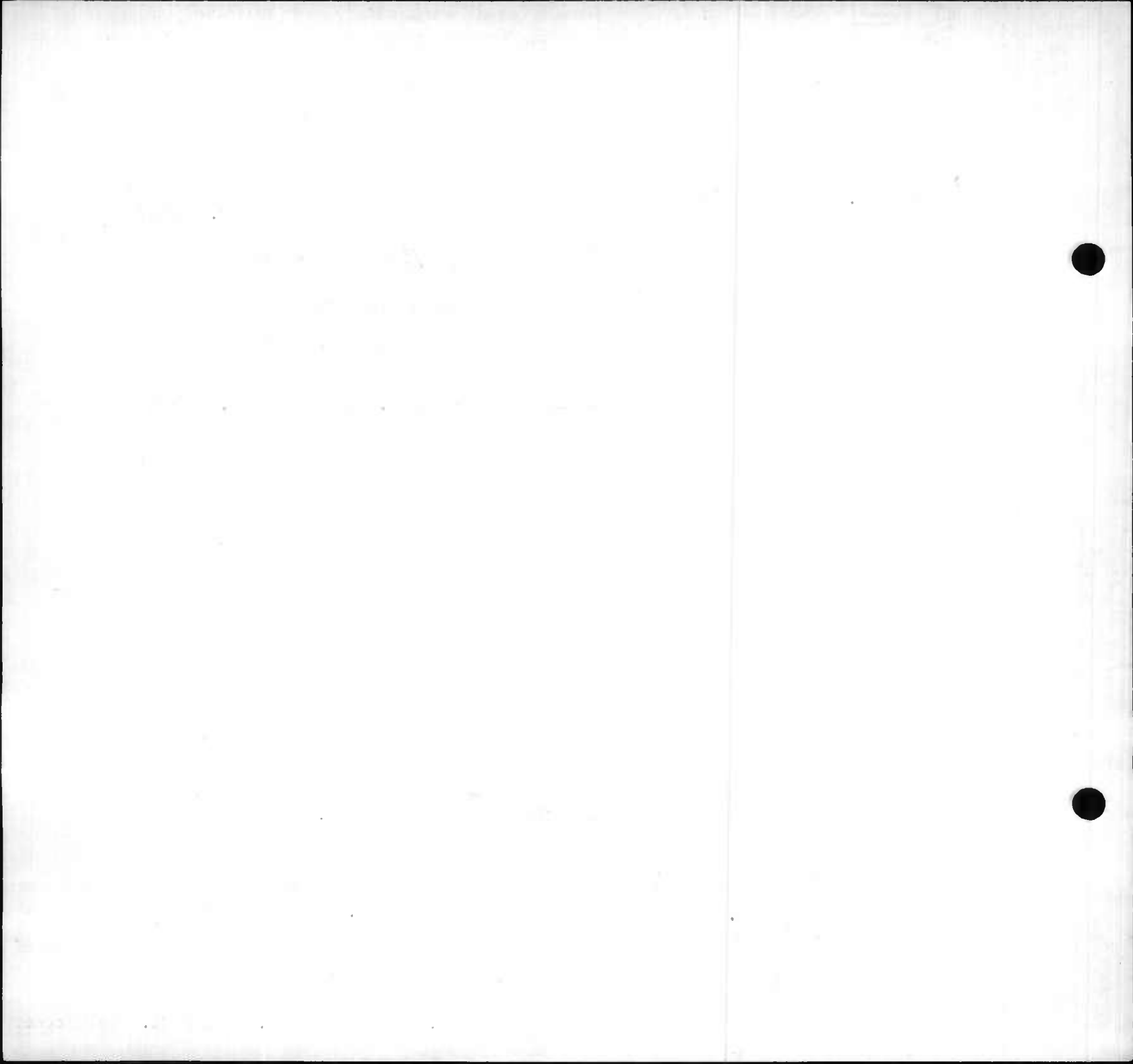


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>86 04461</u> | |
|---|-------------------------|---|--------------------------------------|--|---|
| BIRTH NO. <u>66 04461</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH <u>5-1-66</u> <u>3:25</u> <u>A</u> M. | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>AGNES GRAHN</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <u>BALTIMORE</u> B. COUNTY <u>20-08</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>THE JOHNS HOPKINS HOSPITAL</u>
<u>601 N. BROADWAY 21205</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>MARYLAND</u>
D. STREET ADDRESS (If rural, give location)
<u>276 MONASTERY AVENUE S. 21229</u> | | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED, NEVER MARRIED
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>2/24/1901</u> | 9. AGE (In years last birthday)
<u>65</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Warrington, England</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>England</u> | | 13. FATHER'S NAME
<u>JAMES MCGRIL</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>BRIDGET Godfrey</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>219-34-4377</u> | | 17. INFORMANT ADDRESS (29)
<u>Wesley H. Grahn 276 S. Monastery Avenue</u> | | | |
| 18. <u>340.31</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Septicemic Shock</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Meningitis and Pneumonia</u> | | CAUSE OF DEATH
(A) <u>Septicemic Shock</u>
DUE TO
(B) <u>Meningitis and</u>
DUE TO
(C) <u>Pneumonia</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>about 4 hr.</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>Chronic Liver Disease</u> | | | | | |
| 19A. DATE OF OPERATION
<u>5-1-66</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinite medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At <input type="checkbox"/> Net White <input type="checkbox"/>
Work At Work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>4-29</u> 19 <u>66</u> to <u>5-1</u> 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>5-1</u> 19 <u>66</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Michael A. Davis</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>5-1-66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>MICHAEL A. DAVIS</u>
<u>Michael A. Davis</u> | | 23D. ADDRESS
<u>601 N. BROADWAY 21205</u>
<u>JOHNS HOPKINS HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Entombment</u> | | 24B. DATE
<u>May 4, 66</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Greenmount Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore</u>
<u>Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 2 1966</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Wm. Cook-Brooks, Inc.</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>1217 St. Paul Street</u> | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04462

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GILBERT S. LIBERLES

2. DATE AND HOUR PRONOUNCED DEAD

May 1, 1966 2:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5525 Gwynn Oak Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed

8. DATE OF BIRTH

May 17, 1889

9. AGE (In years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Ned Liberles

14. MOTHER'S MAIDEN NAME

Rosa Rosenfeld

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-03-5098

17. INFORMANT

ADDRESS

Miss Dotti C. Liberles 505 W. University Pkwy. (10)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic and Rheumatic
~~XXXXX~~ Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Phenobarbital Intoxication.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, steel, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

5525 Gwynn Oak Avenue

21D TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
4 29 '66 A.M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Overdose of phenobarbital.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/1/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Cremation

23B. DATE

May 2, 1966

23C. NAME of CEMETERY or CREMATORY

Greenmount Crematory

23D. LOCATION

Baltimore

(City, town, or county)

(State)

Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAY 2 1966

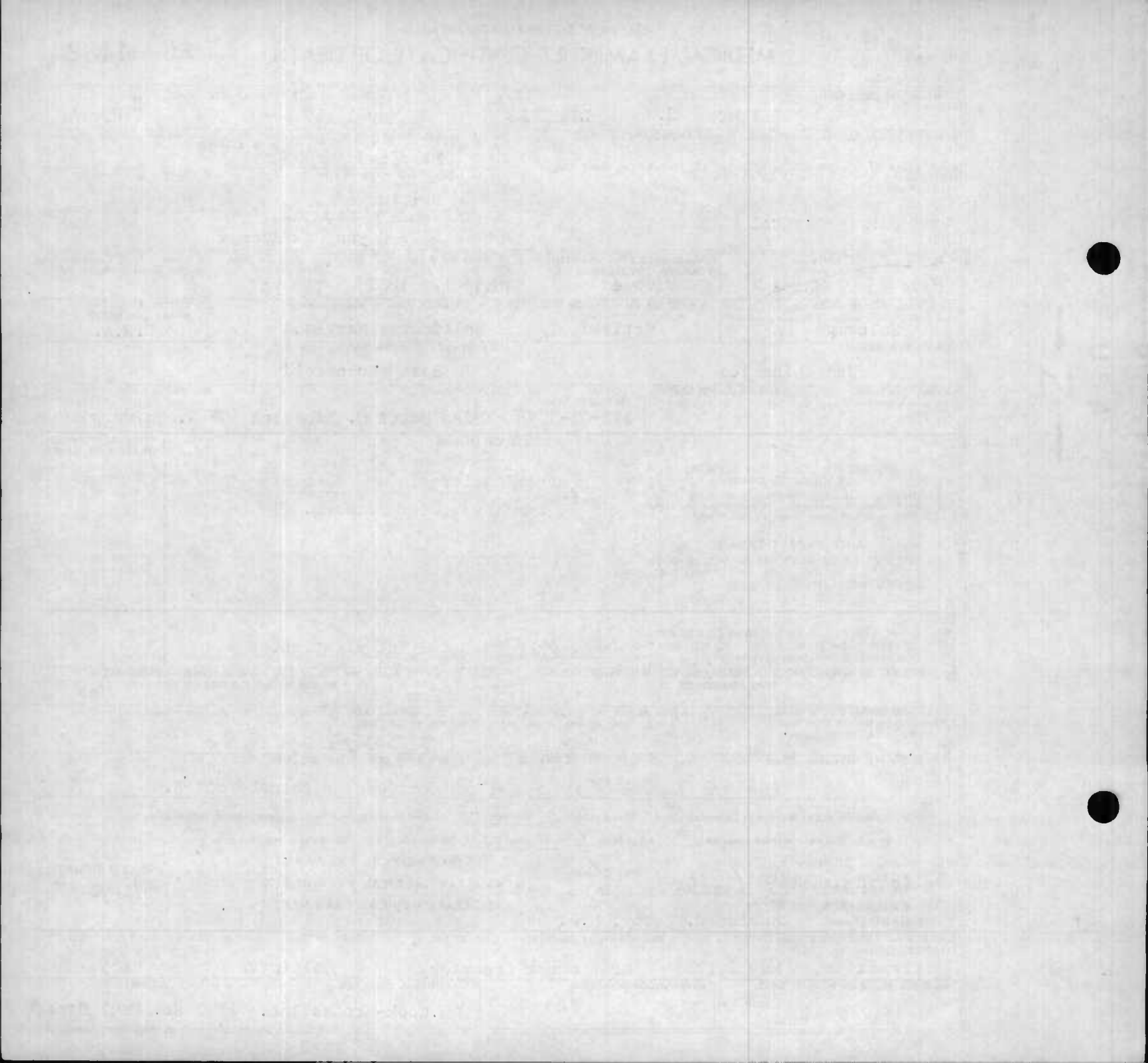
24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Brooks, Inc. 1217 St. Paul Street



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

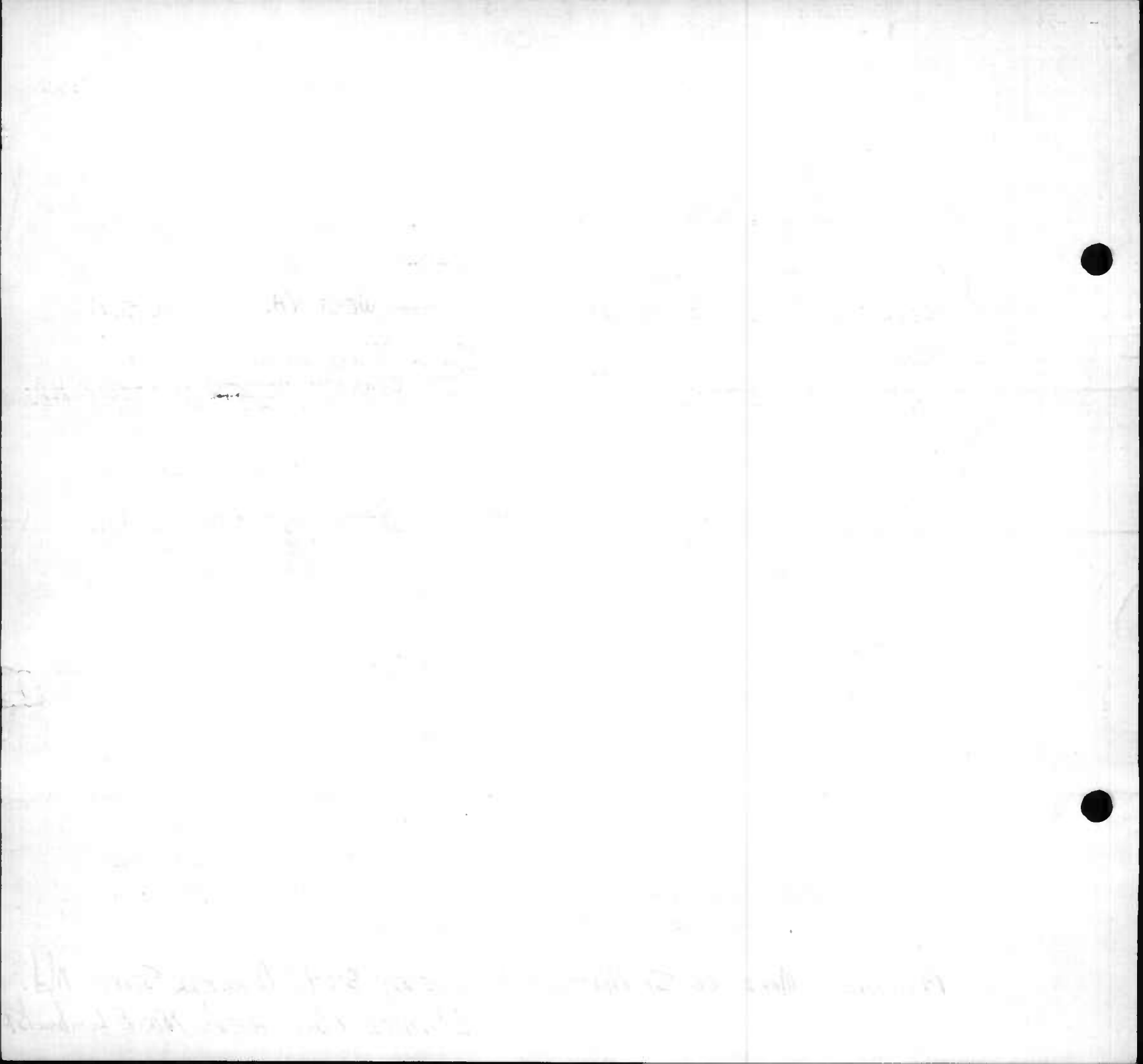
| | | | | | |
|---|-----------|---|--------------------------|---|--|
| BIRTH NO. 66 04463 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04463 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) PITTINGER, JOHN OSCAR | | 2. DATE AND HOUR OF DEATH 5/1/66 11.10 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND B. COUNTY 9-04 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21218 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL | | D. STREET ADDRESS (If rural, give location) 600 E. 30th Street | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 4/14/83 | 9. AGE (In years last birthday) 83 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BALT. TRANSIT CO. (RETIRED) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) OHIO | |
| 12. CITIZEN OF WHAT COUNTRY USA | | 13. FATHER'S NAME David V. Pittinger | | 14. MOTHER'S MAIDEN NAME Laura M. Rhinehart | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-10-1180 | | 17. INFORMANT John D. Pittinger 1916 Valley Rd | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) DUE TO carcinoma, prostate | | INTERVAL BETWEEN ONSET AND DEATH 24 hours | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | (B) DUE TO coronary heart disease with extensive myocardial infarction, old. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. fruit | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/30/66 19 to 5/1/66 19 | | that (I) (we) lost saw the deceased alive on 5/1/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE GODFREY GEH | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 5/1/66 | |
| 23C. PHYSICIAN'S NAME (Type) GODFREY GEH | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5/5/66 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery | |
| 24D. LOCATION (City, town or county) Baltimore, Maryland | | 24E. (State) Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 2 1966 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202 | |

12. IN MEDICAL HOSPITAL

GOLDEN CENT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

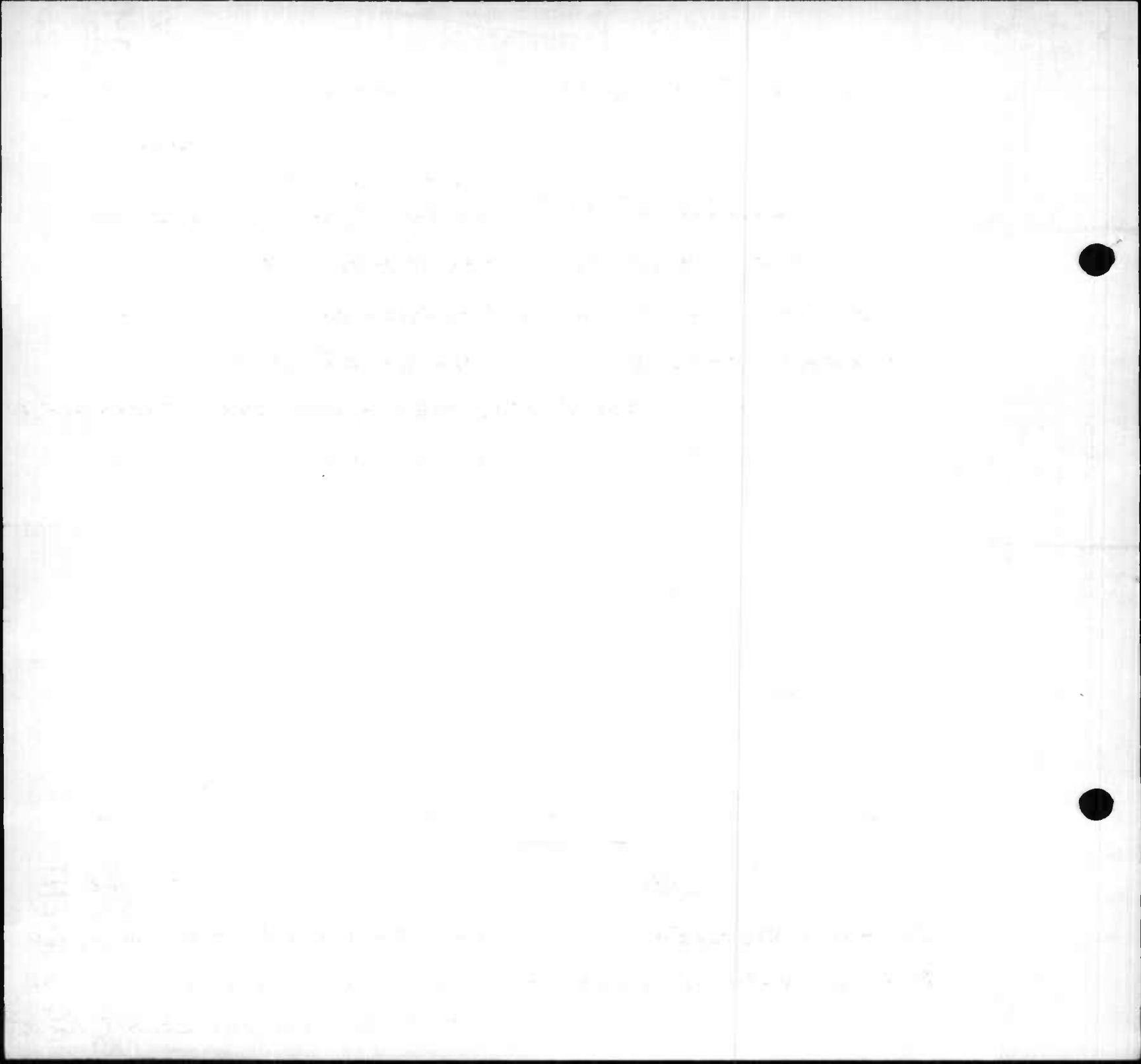
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|--|----------|--|---|--|
| BIRTH NO. 5-610 | | 66 04464 | | 66 04464 | |
| M.E. CASE NO. | | | | 4/27/66 | |
| 1. NAME OF DECEASED (Type or Print) EVELYN SHREVE | | | | 2. DATE AND HOUR OF DEATH 4/27/66 8:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | | | A. STATE MARYLAND B. COUNTY BALTIMORE | |
| 5. SEX FEMALE | | | | 6. RACE WHITE | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SEPARATED | | | | 8. DATE OF BIRTH 11-27-12 | |
| 9. AGE (In years last birthday) 53 | | | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER | | | | 11. BIRTHPLACE (State or foreign country) MARYLAND WEST VA. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME JOHN E WALKER | |
| 14. MOTHER'S MAIDEN NAME CORA TRUMAN | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT BARBARA HANSON ADDRESS 1009 CAYLER DR. RECORDS: BCH 4940 EASTERN AVE #21224 ArLo. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | |
| 19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | None | |
| 21. DATE OF OPERATION 2 None | | | | 22. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 23. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 25. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | | 26. INJURY OCCURRED | |
| 27. HOW DID INJURY OCCUR? | | | | 28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 29. I certify that (1) this hospital attended the deceased from 3/18/66 to 4/27/66, that (2) last saw the deceased alive on 4/27/66 and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above. (1) (Yes) (Did) (Did not) view the body after death. | | | | 30. SIGNATURE Emma McGover Woody M.D. Attending Phys. Med. Director Staff Phys. 4/27/66 | |
| 31. PHYSICIAN'S NAME (Type) DR. EMMA WOODY | | | | 32. ADDRESS 4940 EASTERN AVENUE #21224 | |
| 33. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | 34. DATE MAY 2-66 | |
| 35. NAME OF CEMETERY OR CREMATORY ST MATTHEW'S CEMETERY | | | | 36. LOCATION 6104 O'DONNELL STREET Md. | |
| 37. DATE REC'D BY HEALTH DEPT. MAY 2 1966 | | | | 38. NAME OF REGISTRAR E. J. Feltner | |
| 39. FUNERAL DIRECTOR DIPPEN BROTHERS | | | | 40. ADDRESS 1800 E. Lombard St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04465 | |
|---|-------------------------|--|---|--|---|
| BIRTH NO. 66 04465 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) APELAIDE R. KOPP | | | 2. DATE AND HOUR OF DEATH
APRIL 30 1966 9:20 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY 27-05 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
4705 DUNCREST AVE (G) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | |
| D. STREET ADDRESS (If rural, give location)
6424 ROSEMONT AVE | | | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
MAR 10 1899 64 | 9. AGE (In years last birthday)
67 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CHECKER | | 10B. KIND OF BUSINESS OR INDUSTRY
ACME STORES | | 11. BIRTHPLACE (State or foreign country)
FREDERICKSBURG VA. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
ROBERT HEFLIN | | | |
| 14. MOTHER'S MAIDEN NAME
MARGARET DYER | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
— | | | |
| 16. SOCIAL SECURITY NO.
214-18-9873 | | 17. INFORMANT
GEORGE H. KOPP 4609 SOUTHERN AVE (G) | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Carcinoma of Cervix Uteri | | | INTERVAL BETWEEN ONSET AND DEATH
16 months | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
4/30 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10 1965 to 4/30 1966 , that (I) (we) last saw the deceased alive on 4/29 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Paul B Mueller | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
5/2/66 |
| 23C. PHYSICIAN'S NAME (Type)
DR. PAUL G. MUELLER | | | 23D. ADDRESS
6411 BELAIR RD BALTIMORE MD | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
MAY 4 1966 | | 24C. NAME OF CEMETERY OR CREMATORY
GARDENS OF FAITH | |
| 24D. LOCATION (City, town, or county) (State)
TRUMPSMILL RD BALTO MD | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR
RIPPEL BROS INC. 7110 BELAIR RD MD | | | |

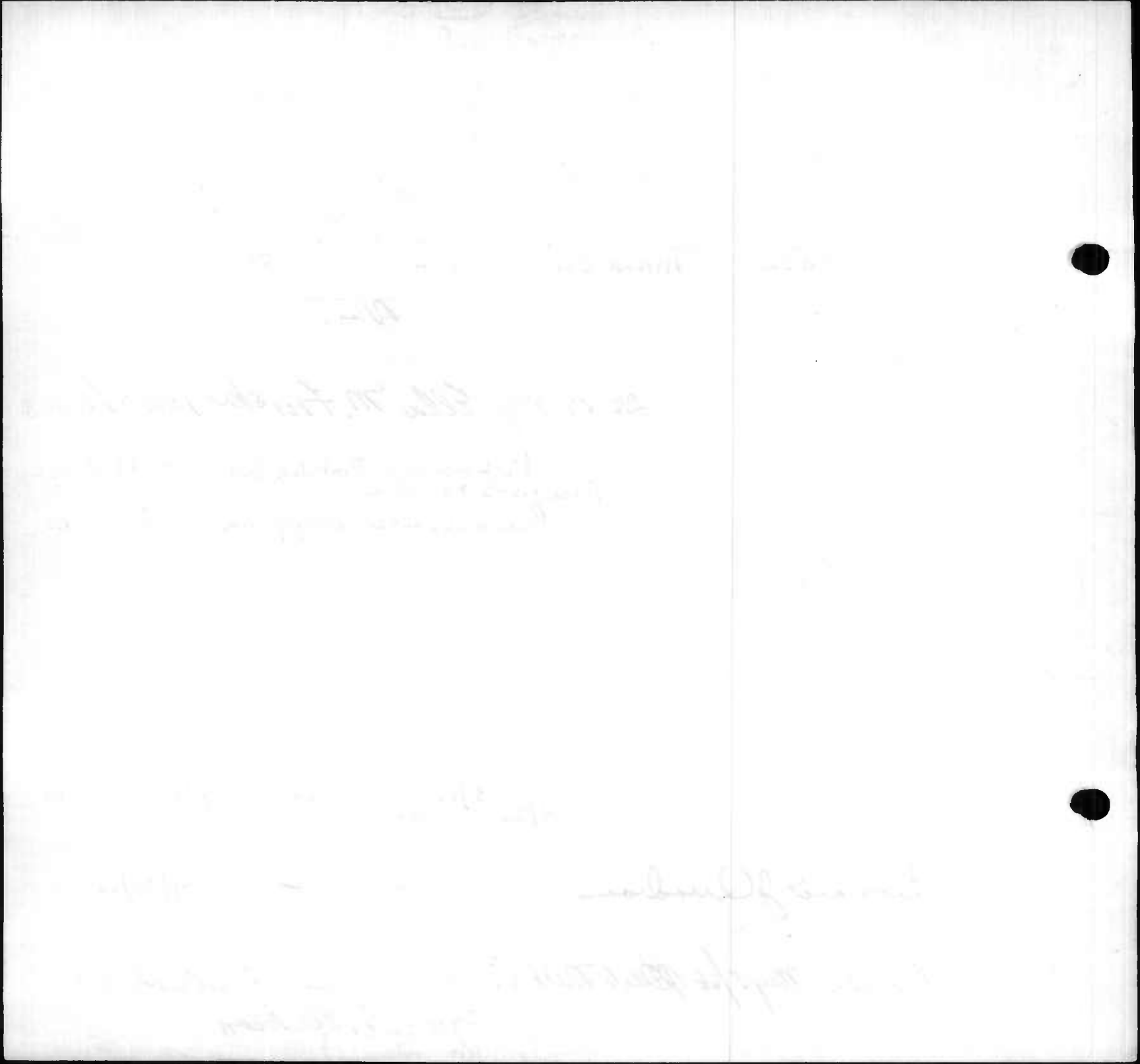


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|--|--|--|---|--|--|------------------------------------|------------------------------|
| BIRTH NO.
66 04466 | | CERTIFICATE OF DEATH | | | | Registered No. 66 04466 | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Archer Fowlkes | | | | 2. DATE AND HOUR OF DEATH
4/30/66 7:25 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1516 East Lanvale Street | | | |
| 5. SEX
MALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
10-11-15 | 9. AGE (In years last birthday)
50 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Steel Worker | | 11. BIRTHPLACE (State or foreign country)
Ala. | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME
Grief Fowlkes | | | 14. MOTHER'S MAIDEN NAME
Nannie Freeland | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO.
216-09-5489 | | | 17. INFORMANT
Ella M. Fowlkes | | | | ADDRESS
1516 E Lanvale | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
PULmonary Embolus-Recumbent 11 days
Pneumococcal EMPYEMA
6 weeks | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 21A. DATE OF OPERATION | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 22A. AUTOPSY? (Yes or No)
YES | | 22B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/19 19 66 to 4/30 19 66 , that (I) (we) last saw the deceased alive on 4/30 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Leonard J. Quadrian | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/30/66 | |
| 23C. PHYSICIAN'S NAME (Type)
Leonard J. Quadrian | | | | | | 23D. ADDRESS
M.D. The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | May 5/66 | | Mount Natl Cem. | | 5501 Frederick Ave | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | 25B. NAME OF REGISTRAR
Robert E. ... | | 25C. FUNERAL DIRECTOR
James T. Ellickson | | ADDRESS | | | |



1
B-546

66 04467 BALTIMORE CITY HEALTH DEPARTMENT 66 04467

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **GEORGE BAUMILLER**

2. DATE AND HOUR PRONOUNCED DEAD **April 30, 1966 2:40 P M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 1-05
D. STREET ADDRESS (If rural, give location)
201 S. Madeira Street

5. SEX **Male** 6. RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **Single** 8. DATE OF BIRTH **April 29/1885** 9. AGE (In years last birthday) **80** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **grave digger** 10B. KIND OF BUSINESS OR INDUSTRY **retired** 11. BIRTHPLACE (State or foreign country) **Baltimore** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **John Baumiller** 14. MOTHER'S MAIDEN NAME **Marjaret Hart**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. **216-09-26949** 17. INFORMANT **Mr. John Baumiller** ADDRESS **1200 E. Biddle St**

18. **42211** I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) **Arteriosclerotic cardiovascular disease** (A) DUE TO (B) DUE TO (C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **2** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) **Yes** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **Yes**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, fam, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Charles S. Petty** M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) **Charles S. Petty, M.D.** DATE SIGNED **5/1/66**

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **4/4/66** 23C. NAME of CEMETERY or CREMATORY **Cathedral** 23D. LOCATION (City, town, or county) (State) **Baltimore**

24A. DATE REC'D BY HEALTH DEPT. **MAY 2 1966** 24B. NAME OF REGISTRAR **Robert E. Fasham** 24C. FUNERAL DIRECTOR **Philip Henry Soro** ADDRESS **2024 Orleans St**

VS 151-REV. 1/1/65

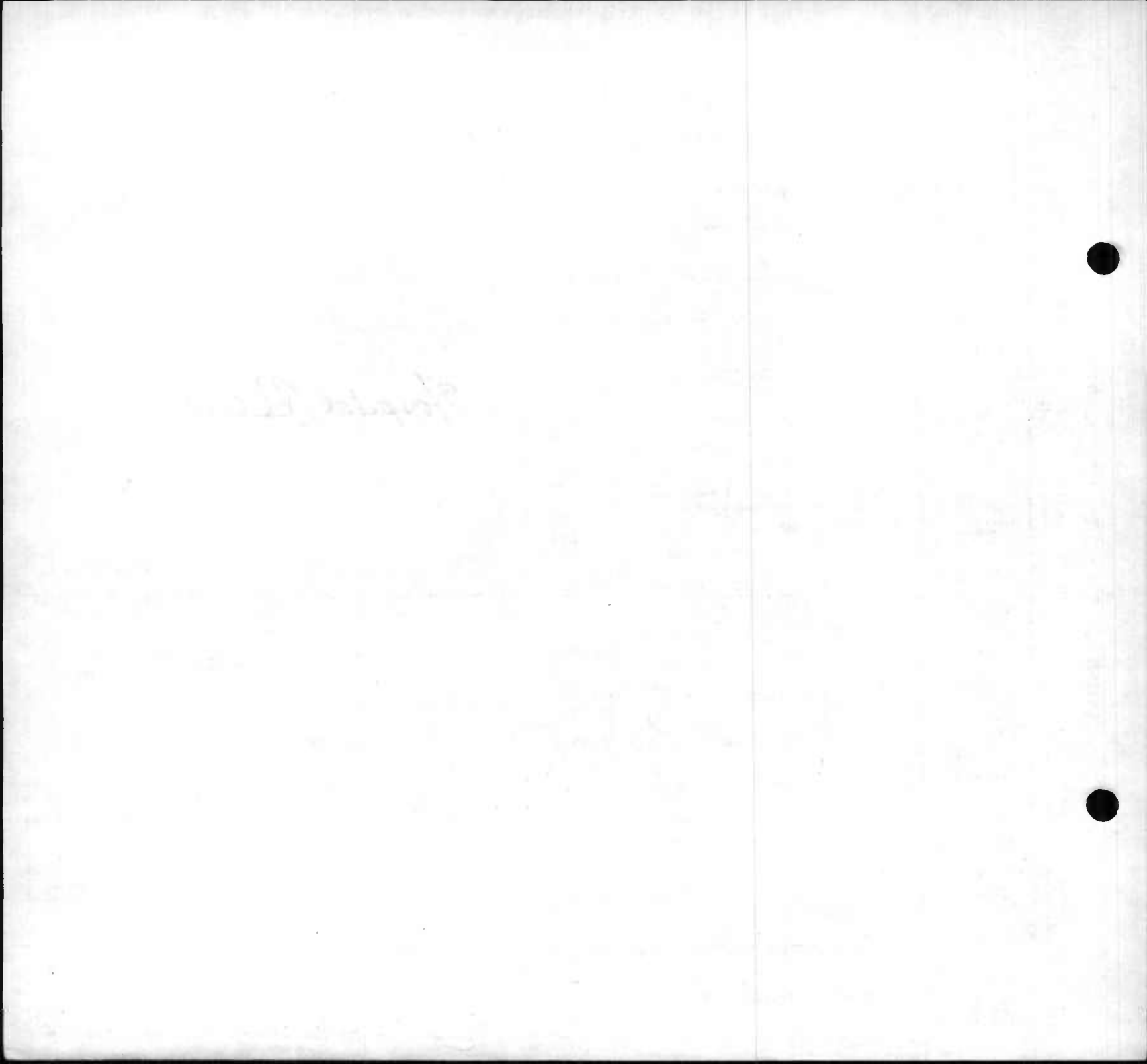
WALTER ROUGE

PAC 601101

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

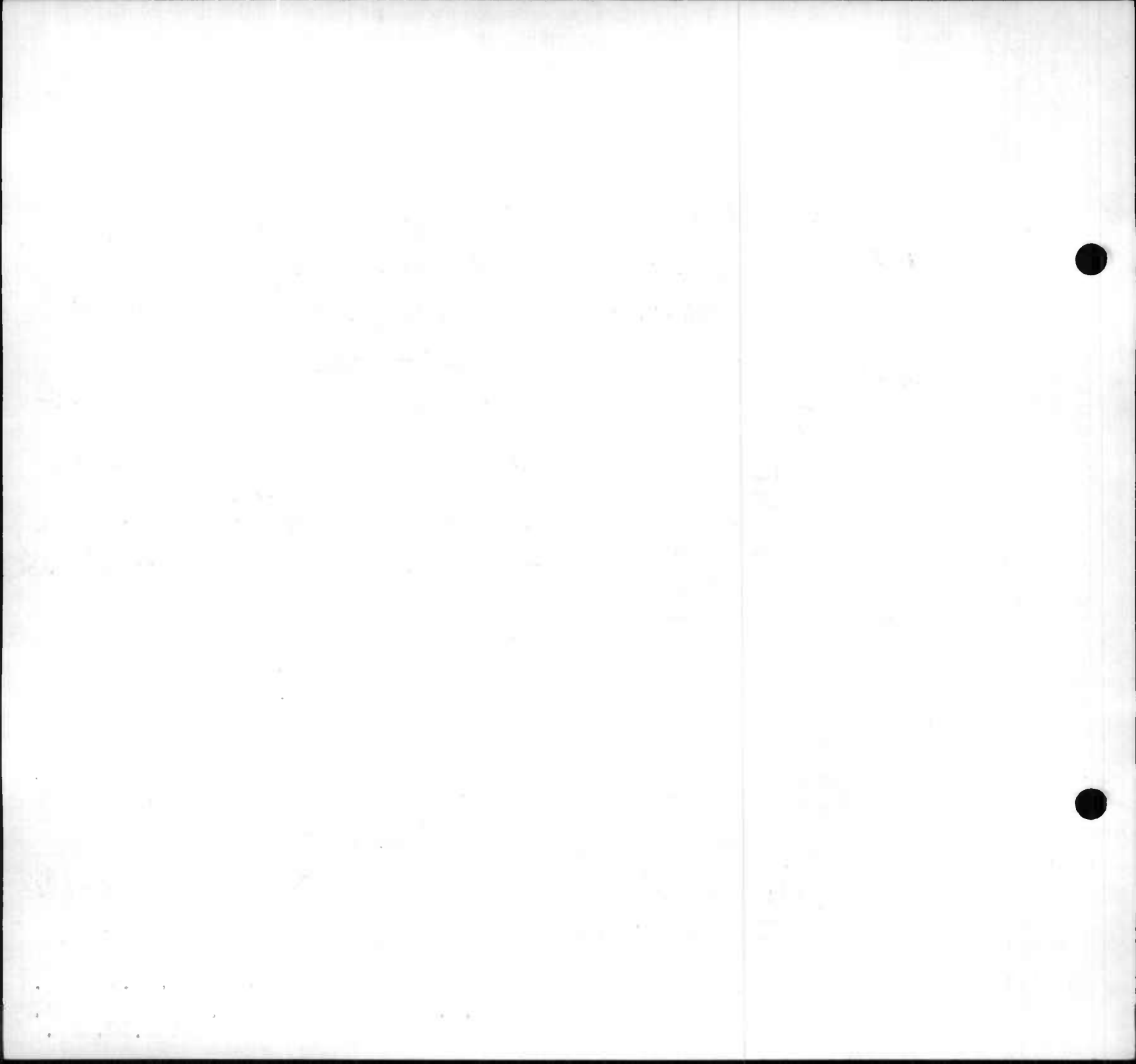
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 04468 | |
|--|------------------|--|--|--|---|--|--|
| BIRTH NO. 66 04468 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ROSA M. BLACKWELL | | 2. DATE AND HOUR OF DEATH 4-27-66 6:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL | | | | A. STATE MD. B. COUNTY BALTIMORE CITY | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 1424 BELVIDERE ST. | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED | | 8. DATE OF BIRTH 5-2-28 | 9. AGE (In years last birthday) 37 | 10. If Under 1 Yr. Months: Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD. | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 13. FATHER'S NAME CHARLES BLACKWELL. | | | | 14. MOTHER'S MAIDEN NAME DAISY MARSHALL | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Hospital Record | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) HEPATIC COMA. | | 2 days | |
| | | | | (B) HEPATIC CIRRHOSIS | | 4 MONS. | |
| | | | | (C) CHRONIC ALCOHOLISM. | | 7 yrs. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No. | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-25-66 19 to 4-27 19 66 , that (I) (we) last saw the deceased alive on 4-27 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Eldon Hawbaker | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 4-27-66 | |
| 23C. PHYSICIAN'S NAME (Type) Eldon Hawbaker | | | | 23D. ADDRESS MERCY HOSPITAL, BALTIMORE, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 4-30-66 | | 24C. NAME OF CEMETERY or CREMATORY MT Calvary Em. A. A. Co. | | 24D. LOCATION (City, town, or county) (State) MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 2 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Rayner Sanders | | ADDRESS 217 E. Preston St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|---|--|
| 66 04469 CERTIFICATE OF DEATH | | | | | | Registered No. 66 04469 | | | | | |
| BIRTH NO. 66 04469 | | | | | | M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) GIESE, MRS NAOMI EMORY | | | | | | 2. DATE AND HOUR OF DEATH
4-30-1966 9 PM | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
MONTEBELLO STATE HOSPITAL | | | | | | A. STATE MARYLAND | | | | | |
| | | | | | | B. COUNTY 27-10 | | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | | | | D. STREET ADDRESS (If rural, give location)
506 ROSSITER AVE. | | | | | |
| 5. SEX IF | | 6. RACE W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
8-4-1898 | | 9. AGE (In years last birthday)
67 | | 10. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSE WIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY
HOUSE WIFE | | | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, M.D. | | | |
| 13. FATHER'S NAME
J. K. B. EMORY | | | | | | 14. MOTHER'S MAIDEN NAME
IDA AMELIA ALLISON | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO.
— | | 17. INFORMANT ADDRESS
MR. LEO C GIESE (Husband) SAME | | | | | |
| 18. 4-20-11
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ACUTE EMBOLISM CEREBRAL x PULMONARY | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1/2 hr. | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
MYOCARDIAL INFARCTION (UNKNOWN) | | | | | | ARTERIOSCLEROTIC C-V. DISEASE (UNKNOWN) | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
PARAPLEGIA | | | | | | ABOUT 3 YEARS | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No)
yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-24-1966 to 4-30-1966 , that (I) (we) last saw the deceased alive on 4-30-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Zin U. Park | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4-30-1966 | | | |
| 23C. PHYSICIAN'S NAME (Type)
ZIN U. PARK | | | | | | 23D. ADDRESS
MONTEBELLO STATE HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/4/1966 | | 24C. NAME OF CEMETERY or CREMATORY
Parkwood | | | | 24D. LOCATION (City, town, or county) (State)
Parkville, Balto. Co., Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | | | 25B. NAME OF REGISTRAR
R. G. E. Feltner | | | | 25C. FUNERAL DIRECTOR ADDRESS
H. W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | |

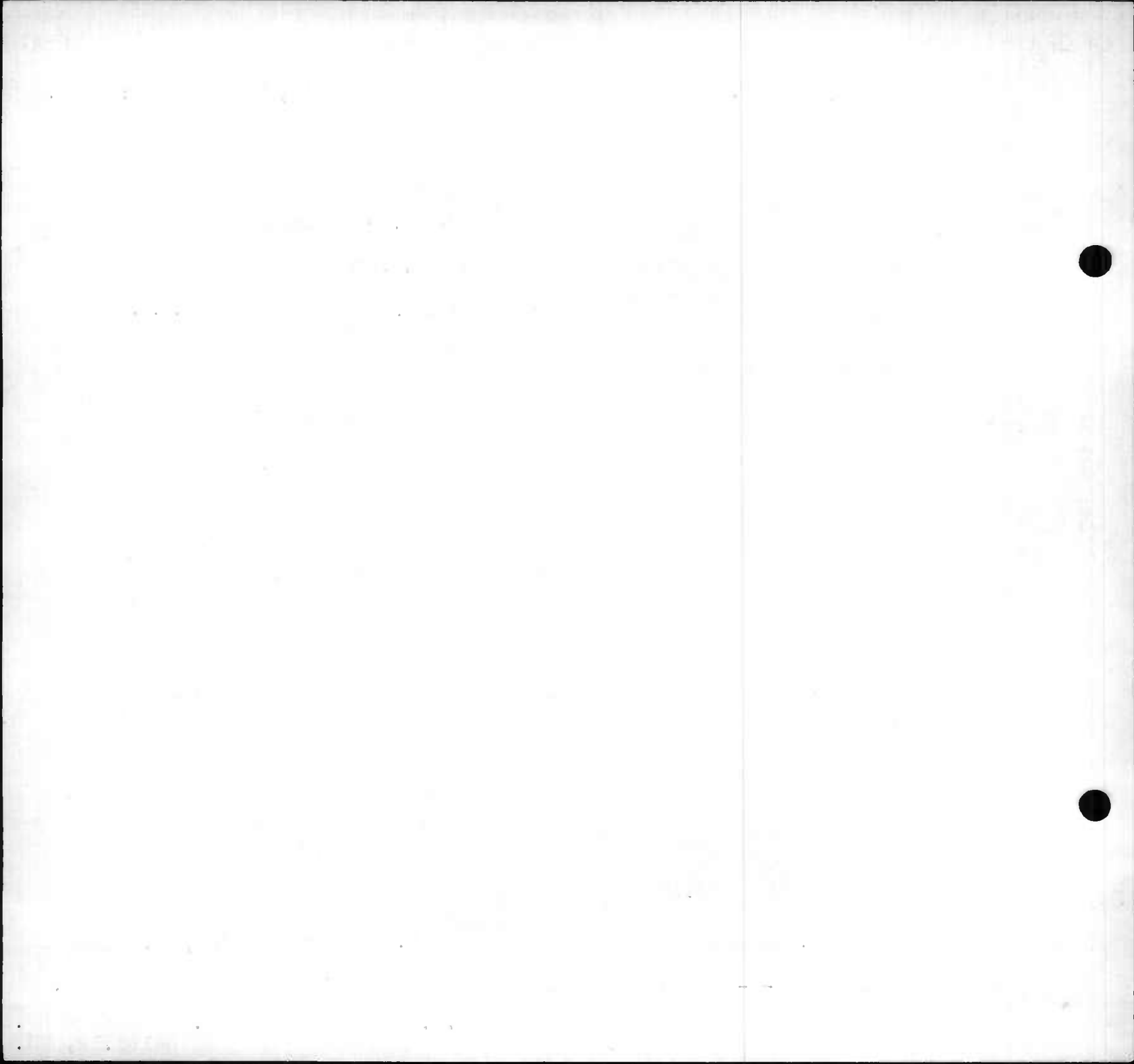


FUNERAL DIRECTOR: IMPORTANT

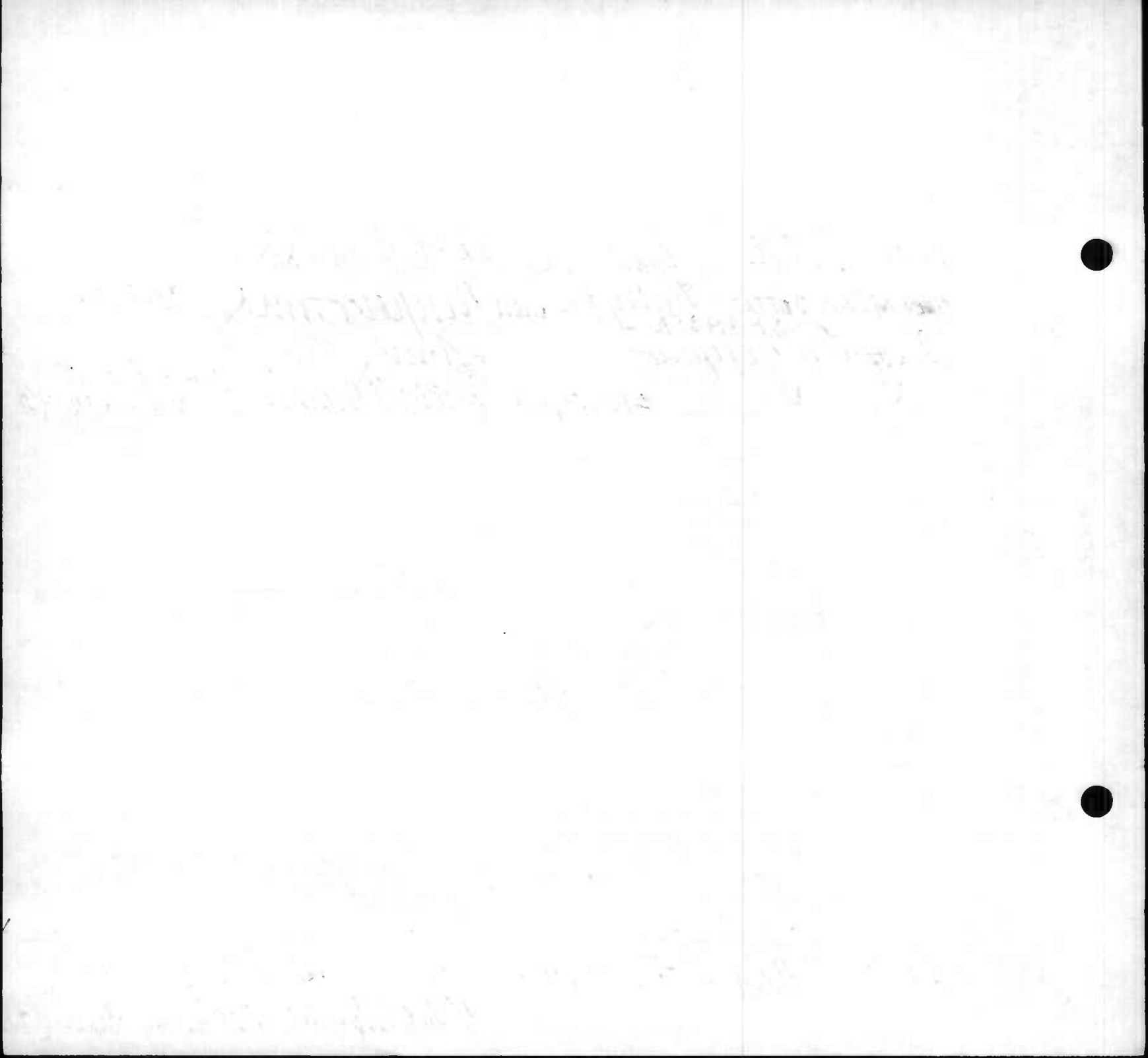
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 66 04470 | | Registered No. | |
|---|-------------------------|--|---|---|--|--|---|
| BIRTH NO. | | | | 66 04470 | | | |
| M.E. CASE NO. | | | | BIRTH NO. | | | |
| 1. NAME OF DECEASED
(Type or Print)
Miller, Lloyd O. | | | | 2. DATE AND HOUR OF DEATH
April 29, 1966 11:46 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Keswick | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
700 W. 40th Street | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
April 3, 1882 | 9. AGE (In years last birthday)
84 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Commerical Agent | | | 10B. KIND OF BUSINESS OR INDUSTRY
Merchants & Miners Transportation | | 11. BIRTHPLACE (State or foreign country)
Balto. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Decatur Howard Miller | | | | 14. MOTHER'S MAIDEN NAME
Agnes Owens | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes World War I | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Elizabeth M. Merrick - R. R. - Keswick | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.)
422.1 + 127X | | | | CAUSE OF DEATH
(A) Atherosclerotic Cardiovascular Disease
DUE TO
(B) Old Cerebro-vascular Accident
DUE TO
(C) Prostatic Adenocarcinoma - operated | | INTERVAL BETWEEN ONSET AND DEATH
2 1/2 yrs
3 yrs. | |
| <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 16 Dec 1963 to 29 Apr 1966 , that (I) (we) lost saw the deceased alive on 29 Apr 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Aubrey D. Richardson | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
29 Apr 1966 | |
| 23C. PHYSICIAN'S NAME (Type)
Aubrey D. Richardson | | | | 23D. ADDRESS
M.D. 700 W. 40th Street Balto. Md. 21211 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
5-2-66 | | 24C. NAME of CEMETERY or CREMATORY
Greenmount | | 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | | | 25B. NAME OF REGISTRAR
Robert E. Jenkins | | 25C. FUNERAL DIRECTOR ADDRESS
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | |



VS 150-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04472 | |
|--|-----------|--|---------------------------|--|--|
| BIRTH NO. 66 04472 | | CERTIFICATE OF DEATH | | Registered No. 66 04472 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Evelyn B. Wilson | | 2. DATE AND HOUR OF DEATH April 30, 1966 2:30 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4411 Underwood Road | | Maryland | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) 4411 Underwood Road | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 9/7/1885 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 13. FATHER'S NAME Charles L. Bareford | | 14. MOTHER'S MAIDEN NAME M. Franklin | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs. Arthur P. Bond (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Inanition (B) Abdominal carcinomatosis (C) | | INTERVAL BETWEEN ONSET AND DEATH Weeks Months | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work Not While At Work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 30 19 66 and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. Attended by Dr. Helfrich. | | | | | |
| 23A. SIGNATURE Richard K. Gundry | | 23B. DATE SIGNED 5-3-66 | | | |
| 23C. PHYSICIAN'S NAME (Type) Richard K. Gundry | | 23D. ADDRESS M.D. 2 W. University Pkwy, Apt. A. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5/3/1966 | | 24C. NAME OF CEMETERY or CREMATORY Cokesbury | |
| | | | | 24D. LOCATION (City, town, or county) Abingdon Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 2 1966 | | 25B. NAME OF REGISTRAR R. E. Johnson | | 25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | |

Abstracts of the
Transactions of the
West

Richard K. Smith
April 20
Attended by Dr. H. H. H.
2-2-2

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

2. DATE AND HOUR PRONOUNCED DEAD

William H. Walker

4/29/66 5:15 a. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Harford

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Belair

D. STREET ADDRESS (If rural, give location)

Rt. 2 Box 176 A

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

10-15-1897

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Self Employed

10B. KIND OF BUSINESS OR INDUSTRY

Contracting

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Walker

14. MOTHER'S MAIDEN NAME

Isabel Jenkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes WW 1-11

16. SOCIAL
SECURITY NO.

220-18-6015A David H. Walker

17. INFORMANT

ADDRESS

Belair, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Rte. 40 near Ebenezer Rd.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

4 29 66 4:28 a. m.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

driver of auto which collided with truck

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/29/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5-2-66

23C. NAME of CEMETERY or CREMATORY

Dulaney Valley

23D. LOCATION

Timonium

(City, town, or county)

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 2 1966

R. E. F. J. J.

H.W. Jenkins & Sons Co. 4905 York Rd.

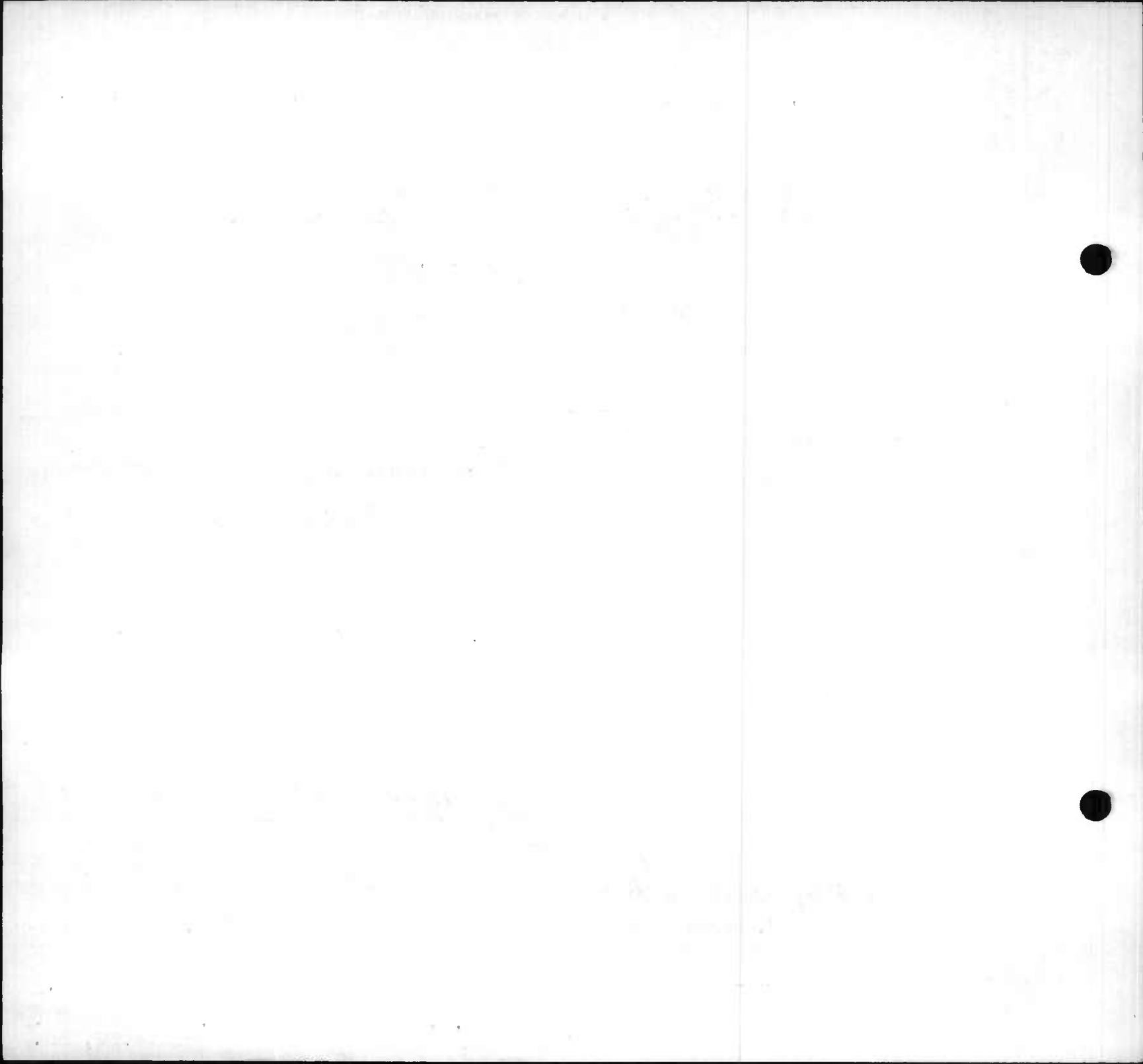
Balto. 12, Md.

RECEIVED
FBI
JAN 10 1964

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

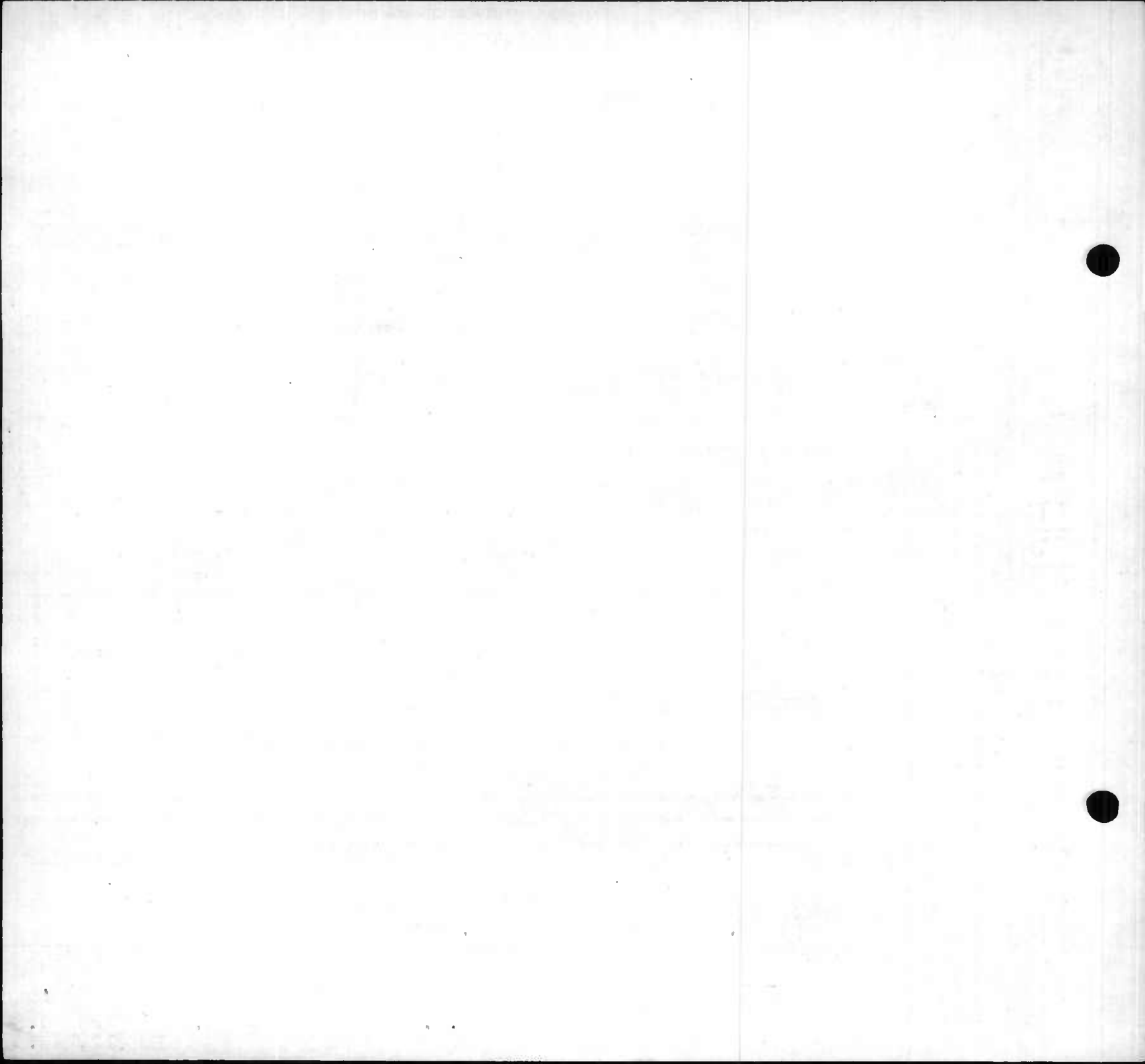
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04474 | |
|---|--------------|---|----------------------------------|---|---|
| BIRTH NO. 66 04474 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH
April 29, 1966 1:00 P. M. | | | |
| 1. NAME OF DECEASED
(Type or Print)
NOLAN, Lawrence A. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
JENKINS MEMORIAL HOSPITAL
1000 S Caton Ave.
Baltimore, Md. 21229 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
2714 N Howard St. | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
Feb. 2, 1880 | 9. AGE (In years lost birthday)
86 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Accountant | | 10B. KIND OF BUSINESS OR INDUSTRY
Business (Oil) | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Bartholomew Nolan | | 14. MOTHER'S MAIDEN NAME
Anna Burns | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-01-7258 | | 17. INFORMANT
MEDICAL RECORDS ROOM - Jenkins Memorial | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Pneumonia | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
29 hrs
5 days | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Arteriosclerotic Heart Disease | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/10/66 to 4/29/66, that (I) (we) last saw the deceased alive on 4/29/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
J. Raymond Gladue | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/30/66 | |
| 23C. PHYSICIAN'S NAME (Type)
J. Raymond Gladue | | 23D. ADDRESS
Jenkins Memorial Hospital, 1000 S Caton Ave | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-2-66 | | 24C. NAME OF CEMETERY or CREMATORY
Holy Redeemer | |
| 24D. LOCATION
Baltimore | | 24E. (State)
Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | 25B. NAME OF REGISTRAR
J. Raymond Gladue | | 25C. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 66 04475 | |
|--|----------------------|---|--|---|--|--|--|--|--|--|--|
| BIRTH NO. 66 04475 | | CERTIFICATE OF DEATH | | | | | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) OTTO E. VOISINET | | | | 2. DATE AND HOUR OF DEATH
4/29/66 555 P. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
MARYLAND GENERAL Hosp
BALTO MD. | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Balto 21207 53-00 | | | | | |
| D. STREET ADDRESS (If rural, give location)
4405 Springhill Ave | | | | | | | | | | | |
| 5. SEX
M | 6. RACE
Ca | 7. MARRIED, NEVER MARRIED
<input checked="" type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify) | | 8. DATE OF BIRTH
1/23/93 | | 9. AGE (in years last birthday) 73 | | If Under 1 Yr. Months: Days: Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Sales | | 11. BIRTHPLACE (State or foreign country)
New York | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
Louis Voisinet | | | | | | 14. MOTHER'S MAIDEN NAME
Caroline Besch | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES WWI | | | | 16. SOCIAL SECURITY NO.
023-01-0250 | | 17. INFORMANT
Daughter Christine Sullivan | | | ADDRESS
5916 Fenwick Ave | | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
PULMONARY EDEMA | | | | | | CAUSE OF DEATH
colony occlusion | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
ARTEROSCLEROSIS & HYPERTENSIVE CARDIOVASCULAR DISEASE | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/29 1966 to 4/29 1966 that (I) (we) last saw the deceased alive on 4/29 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Donald T. Lewers | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
4/29/66 | | |
| 23C. PHYSICIAN'S NAME (Type)
Donald T. Lewers | | | | | | 23D. ADDRESS
M.D. Md. General Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-2-66 | | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1966 | | | | 25B. NAME OF REGISTRAR
R. E. Sullivan | | | | 25C. FUNERAL DIRECTOR ADDRESS
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04476 | |
|---|----------------------|--|------------------------------------|--|--|
| BIRTH NO. 66 04476 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Jones, Samuel | | 2. DATE AND HOUR OF DEATH
4-30-66 10:25 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE BALTIMORE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
THE JOHNS HOPKINS HOSPITAL
601 N BROADWAY 21205 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
MARYLAND | | | |
| | | D. STREET ADDRESS (If rural, give location)
1649 NORMAL AVENUE 21213 | | | |
| 5. SEX
M. | 6. RACE
N. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
N. | 8. DATE OF BIRTH
2/10/97 | 9. AGE (In years last birthday)
69 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
JAMES JONES | | 14. MOTHER'S MAIDEN NAME
OLIVIA WILLIAMS | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 331X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Intracerebral Hemorrhage Hypertension | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
4/29/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Intracerebral Hemorrhage | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 6:25 AM 4/29 1966 to 10:25 PM 4/30 1966 that (1) (we) last saw the deceased alive on 4/30- 7:00 PM 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
R.A. Ratchenson | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. A | | 23B. DATE SIGNED
4/30/66 | |
| 23C. PHYSICIAN'S NAME (Type)
R.A. RATCHENSON | | M.D. 23D. ADDRESS
THE JOHNS HOPKINS HOSPITAL
601 N. BROADWAY 21205 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-4-66 | | 24C. NAME OF CEMETERY or CREMATORY
Enfield N.C. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1966 | | 25B. NAME OF REGISTRAR
R. E. Farkas, M.D. | | 25C. FUNERAL DIRECTOR
William Wainwright
2700 Edmondson Ave. | |

THE
MUSEUM
OF
THE
CITY OF
NEW YORK

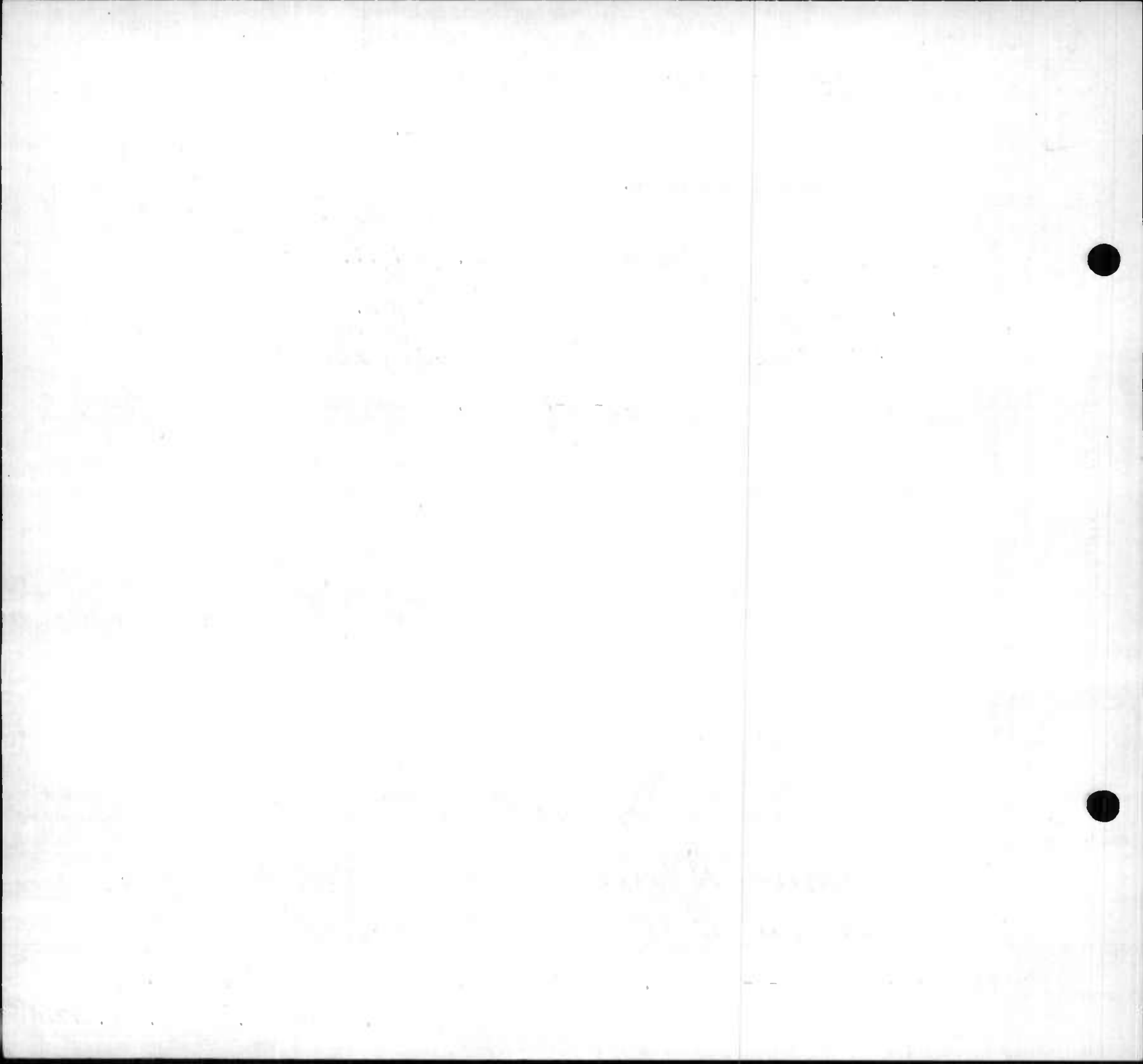
THE
MUSEUM
OF
THE
CITY OF
NEW YORK

THE
MUSEUM
OF
THE
CITY OF
NEW YORK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

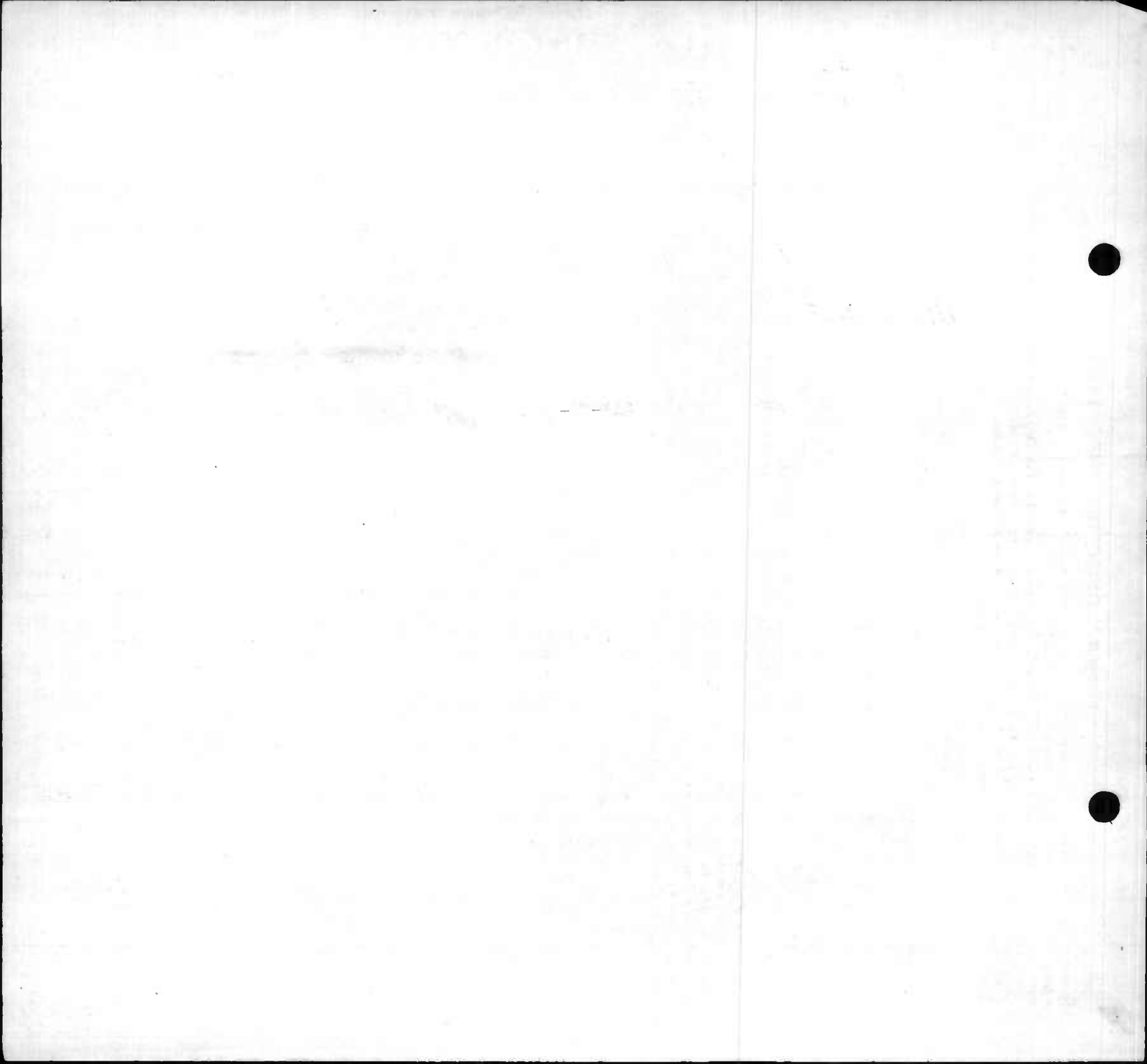
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|----------------------|---|--|---|---|---|--|----------------------|--|
| REGISTERED NO. 66 04477 | | | | | 66 04477 | | | | |
| BIRTH NO. 66 04477 | | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | |
| M.E. CASE NO. (Teresa) | | | | | REGISTERED NO. 66 04477 | | | | |
| 1. NAME OF DECEASED (Type or Print) TERESA MARY KWIATKOWSKI | | | | | 2. DATE AND HOUR OF DEATH 5/1/66 6:45 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6236 Falkirk Rd. | | | | | A. STATE Md. 8. COUNTY 27-38 | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #12 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 6236 Falkirk Road | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Aug. 5, 1911 | 9. AGE (In years last birthday) 54 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab. Technician | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Conn. | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Dominic Vitale | | | | | 14. MOTHER'S MAIDEN NAME Marie Perleoni | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 215-32-1932 | | 17. INFORMANT Mr. Walter Kwiatkowski | | ADDRESS (Same) | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) Carcinoma Stomach | | 3 1/2 mo. | | |
| ANTECEDENT CAUSES | | | | | (B) DUE TO | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (C) DUE TO | | | | |
| II | | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Healed fracture pulmonary 7 BC | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 15 1966 19 to May 1 1966 , that (I) (we) last saw the deceased alive on April 29 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Milton B. Kress M.D. | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 5/1/66 | | |
| 23C. PHYSICIAN'S NAME (Type) MILTON B. KRESS M.D. | | | | | 23D. ADDRESS Medicine at Bay Balto Md | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 5-6-66 | | 24C. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | | 24D. LOCATION (City, town, or county) (State) New Britain, Conn. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 3 1966 | | | 25B. NAME OF REGISTRAR R. E. Galt | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. | | | ADDRESS 21214 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed.

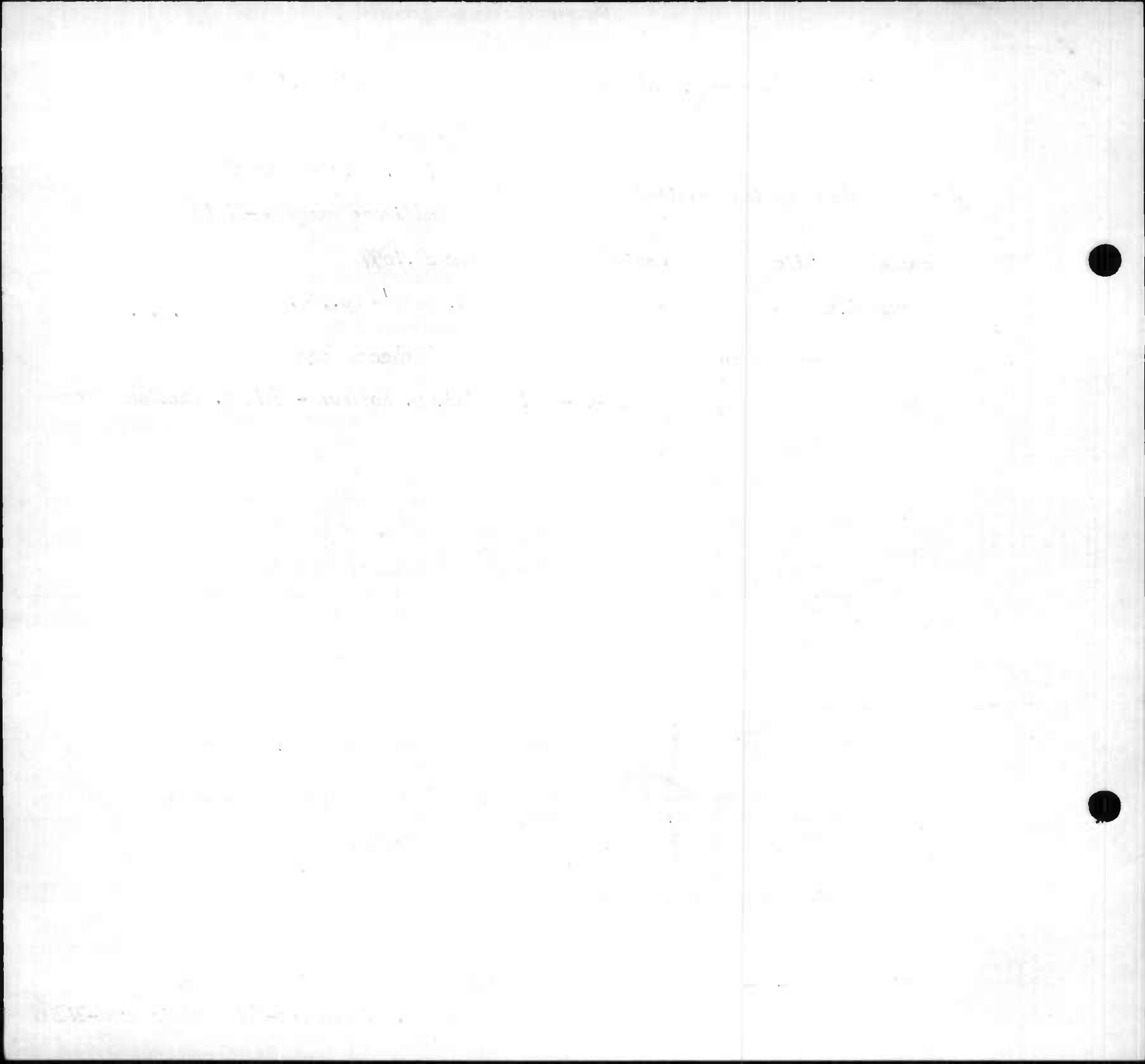
| BIRTH NO. 66 04478 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 04478 | |
|--|---------------------|---|--|---|--|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) JOHN BOBLITZ | | | | 2. DATE AND HOUR OF DEATH
4/28/66 8:55 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)
A. STATE MARYLAND B. COUNTY 12-02 | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
4 Maryland General Hospital | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
3231 ABELL AVE. | | | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | | 8. DATE OF BIRTH
10/13/88 | 9. AGE (In years last birthday)
77 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mechanist CROWN CORN + SEAL | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
BALTO, MD | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
FRANK BOBLITZ | | | | 14. MOTHER'S MAIDEN NAME
Cecelia ALBAN | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNKNOWN No | | | | 16. SOCIAL SECURITY NO.
213-01-0279 | | 17. INFORMANT
Lula E Boblitz | | ADDRESS
SAME | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
13-4X1 | | | | CAUSE OF DEATH
(A) PULMONARY INFARCTION
DUE TO
(B) VENOUS THROMBOSIS - ?
DUE TO
(C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH
4 hrs 40 min | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
CARCINOMA OF RECTUM & METAS | | | | | | | | | |
| 19A. DATE OF OPERATION
3/26/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
CA RECTUM | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/26/66 19 66 to 4/28 19 66 , that (I) (we) last saw the deceased alive on 4/26 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Donald Goldner MD | | | | 23B. DATE SIGNED
4/26/66 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2 May 66 | | 24C. NAME of CEMETERY or CREMATORY
Grave Run Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore Co. Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1966 | | | | 25B. NAME OF REGISTRAR
Robert E. Fisher | | 25C. FUNERAL DIRECTOR
Byrgee Faggert/Honig 3631 Falls Rd | | | |
| | | | | ADDRESS
Norac W Junga Jr | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|--|--|--|--|---|----------------------|--|--|--|--|--|--|------------------------------|--|--|
| BIRTH NO. 66 04479 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 04479 | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Florence A. Hoffman</i> | | | | | | | | | | 2. DATE AND HOUR OF DEATH
<i>April 26, 1966</i> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

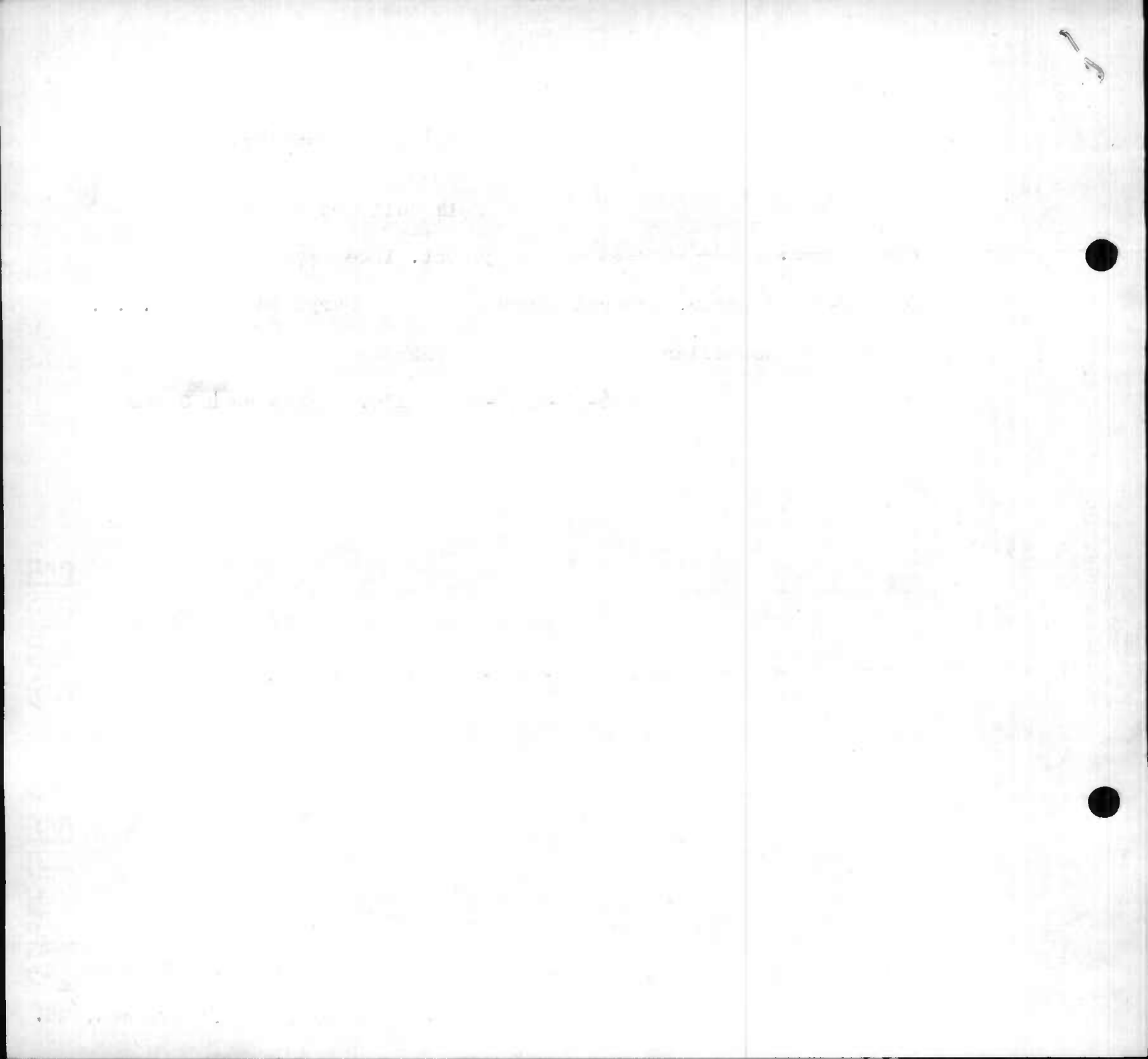
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>33 Johns Hopkins Hospital</i> | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY <i>8-03</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>2419 E. Preston Street</i>
D. STREET ADDRESS (If rural, give location)
<i>Baltimore Maryland-21213</i> | | | | |
| 5. SEX
<i>Female</i> | | 6. RACE
<i>White</i> | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Married</i> | | 8. DATE OF BIRTH
<i>June 24, 1899</i> | | 9. AGE (In years last birthday)
<i>66</i> | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>St. Mary's Co., Md.</i> | | | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | | |
| 13. FATHER'S NAME
<i>Joseph Gatton</i> | | | | | | 14. MOTHER'S MAIDEN NAME
<i>Rebecca Curry</i> | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | | 16. SOCIAL SECURITY NO.
<i>218-14-5061</i> | | 17. INFORMANT
<i>Philip O. Hoffman - 2419 E. Preston Street</i> | | | | ADDRESS | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<i>4 2011 I</i>
CAUSE OF DEATH
(A) DUE TO <i>coronary occlusion</i>
<i>coronary sclerosis</i>
(B) DUE TO <i>hypertension</i>
(C) <i>arterio sclerosis</i>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>II</i>
MEDICAL CERTIFICATION
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<i>Varicose ulcers Right leg.</i> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Sept. 1 1965</i> to <i>April 26 1966</i> , that (I) (we) last saw the deceased alive on <i>April 26 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE
<i>Walter A. Anderson</i> M.D. | | | | | | | | | | 23B. DATE SIGNED
<i>April 27-66</i> | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS
M.D. | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>4-30-66</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Loudon Park Cemetery</i> | | | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore Maryland</i> | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>MAY 3 1966</i> | | | | 25B. NAME OF REGISTRAR
<i>Robert E. Farley, M.D.</i> | | | | 25C. FUNERAL DIRECTOR
<i>John C. Miller Inc-6415 Belair Road-21206</i> | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

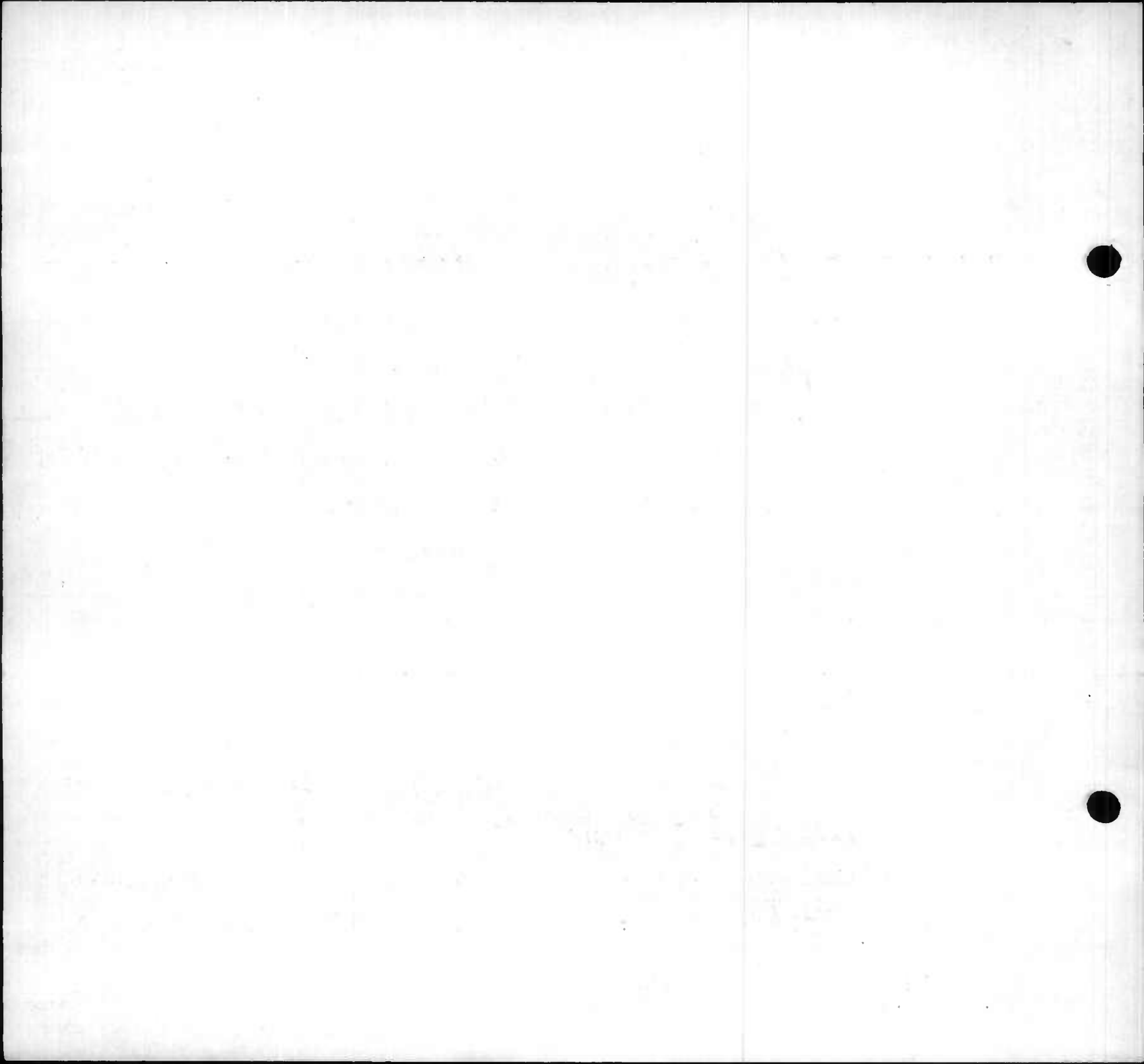
| | | | | | |
|--|-----------------|---|---|--|---|
| BIRTH NO.
66 04480 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No.
66 04480 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print)
Mr Solomon O. Gosweiler | | 2. DATE AND HOUR OF DEATH
4-30-66 9:10 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland
B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
2914 Guilford Ave
Baltimore 18 Md | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location)
2914 Guilford Avenue | | | |
| 5. SEX
Male | 6. RACE
Cau. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
30 Oct. 1888 | 9. AGE (in years last birthday)
77 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Merchant-Storekeeper, General Store |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Merchant-Storekeeper, General Store | | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Solomon Gosweiler | | | 14. MOTHER'S MAIDEN NAME
Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-26-3318-AB | | 17. INFORMANT
Wife, Same as 40C&D | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
163 X I
CAUSE OF DEATH
(A) Carcinoma of lung
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
1 yr. | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Arterio sclerotic cardiovascular disease | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from November 19 58 to April 30 19 66, that (I) (we) last saw the deceased alive on April 29 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Alfred G. Ossman Jr | | | | 23B. DATE SIGNED
4-30-66 | |
| 23C. PHYSICIAN'S NAME (Type)
Alfred G. Ossman Jr | | 23D. ADDRESS
1010 St Paul St Baltimore Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/3/66 | | 24C. NAME OF CEMETERY or CREMATORY
St Paul Lutheran Cemetery Aberdeen, Maryland | |
| 24D. LOCATION (City, town, or county) (State)
Aberdeen, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1966 | | 25B. NAME OF REGISTRAR
Robert E. Tarrington | | 25C. FUNERAL DIRECTOR
Tarrington Funeral Home, Aberdeen, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

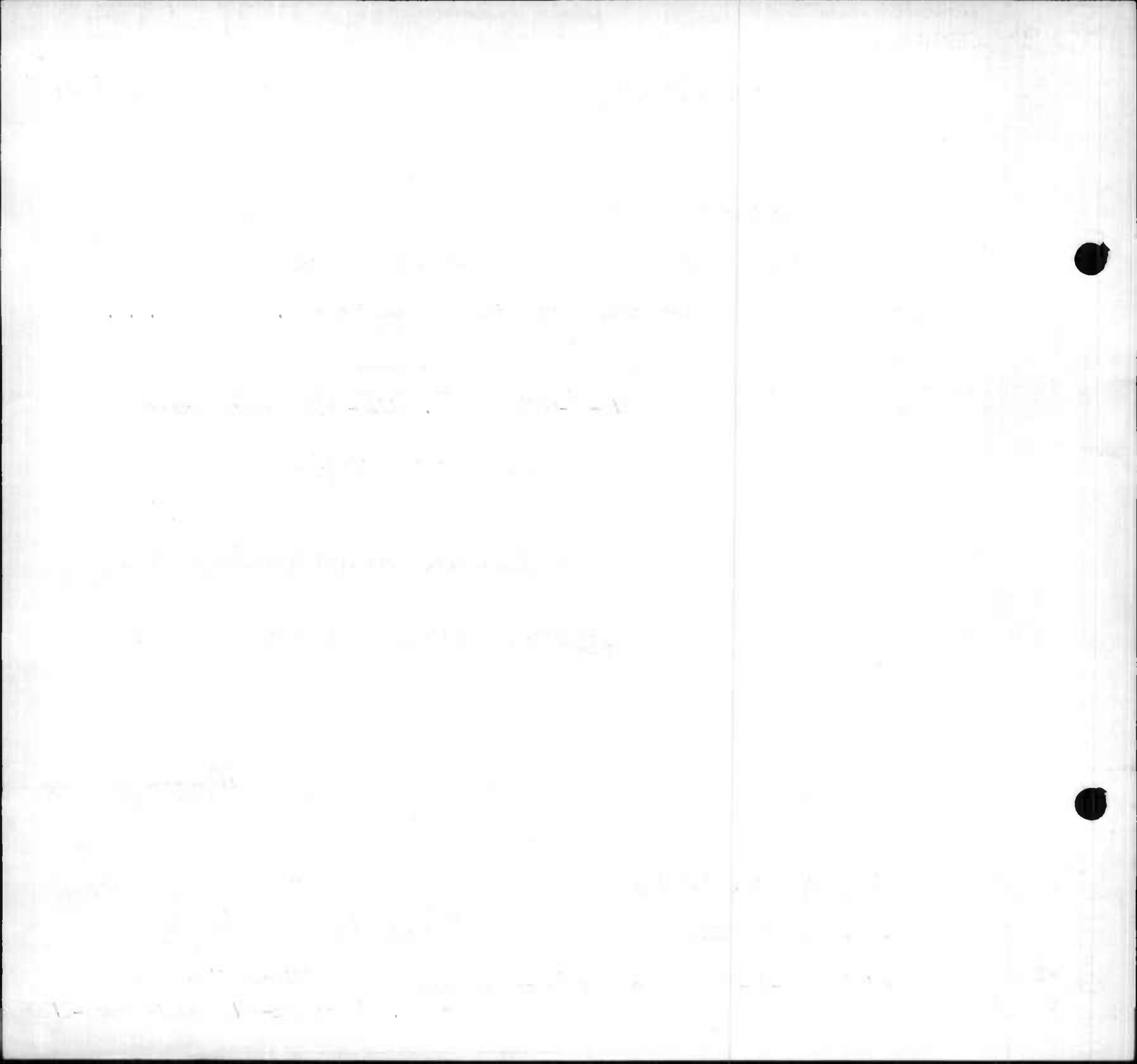
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 68 04481 | |
|--|---------------|--|--|--|--|--|-------------------------------------|
| BIRTH NO. 68 04481 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Edwin L. Marr | | 2. DATE AND HOUR OF DEATH April 29, 1966 7-30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 25-41 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 3631 McTavish Ave 21229 | | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 12/11/01 | 9. AGE (In years last birthday) 64 | 10. Under 1 Yr. Months: Days | | 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician | | | 10B. KIND OF BUSINESS OR INDUSTRY Electric | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Robert Marr | | | | 14. MOTHER'S MAIDEN NAME Ann Burrill | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.I | | 16. SOCIAL SECURITY NO. 219-10-7115 | | 17. INFORMANT Leona P. Marr 3631 McTavish Ave | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) DUE TO Acute coronary occlusion minutes | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO ACVD myocardium months | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO Aneurysm months | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Generalized arteriosclerosis months | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from May 27 1964 to April 2 1966 that (I) (we) last saw the deceased alive on April 2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Henry Arimanas | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED May 2, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) HENRY ARIMANAS | | | | 23D. ADDRESS 1934 Wilken Ave Balto 23, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5/3/66 | | 24C. NAME OF CEMETERY or CREMATORY London Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 3 1966 | | 25B. NAME OF REGISTRAR R. E. Johnson | | 25C. FUNERAL DIRECTOR Walters Funeral Home Pratt & Stricker | | ADDRESS St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 04482</u> | |
|---|-------------------------|---|------------------------------------|--|---|
| BIRTH NO. <u>66 04482</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Joseph Henry</u> | | 2. DATE AND HOUR OF DEATH
<u>4/26/66</u> <u>10:45 A</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>The Johns Hopkins Hospital</u> | | A. STATE <u>Maryland</u>
B. COUNTY <u>Baltimore</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u>
D. STREET ADDRESS (If rural, give location)
<u>4306 Berger Avenue</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Single</u> | 8. DATE OF BIRTH
<u>8-25-41</u> | 9. AGE (In years last birthday)
<u>24</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Clerk</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Blue Cross & Blue Shield</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>Grady Henry</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Anna Hill</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>Yes</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>219-38-0024</u> | | 17. INFORMANT ADDRESS
<u>Ida E. Hill - 4306 Berger Avenue</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
<u>Respiratory insufficiency</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 hrs.</u> | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>Pneumonia</u>
DUE TO
<u>days</u> | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) <u>Cardiac Arrest (coma)</u>
DUE TO
<u>Weeks</u> | | | |
| 21. MEDICAL CERTIFICATION
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>pulmonary emboli</u> | | 22. INTERVAL BETWEEN ONSET AND DEATH
<u>Wks</u> | | | |
| 19A. DATE OF OPERATION
<u>4/26/66</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>he</u> (this hospital) attended the deceased from <u>4/26</u> 19 <u>66</u> to <u>4/26</u> 19 <u>66</u> , that <u>we</u> last saw the deceased alive on <u>4/26</u> 19 <u>66</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>He</u> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>W. H. Spencer III MD</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>4/26/66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>W. H. Spencer III</u> | | 23D. ADDRESS
<u>John's Hopkins Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4-30-66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Holy Redeemer Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 3 1966</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>John C. Miller Inc-6415 Belair Road -21206</u> | | | |



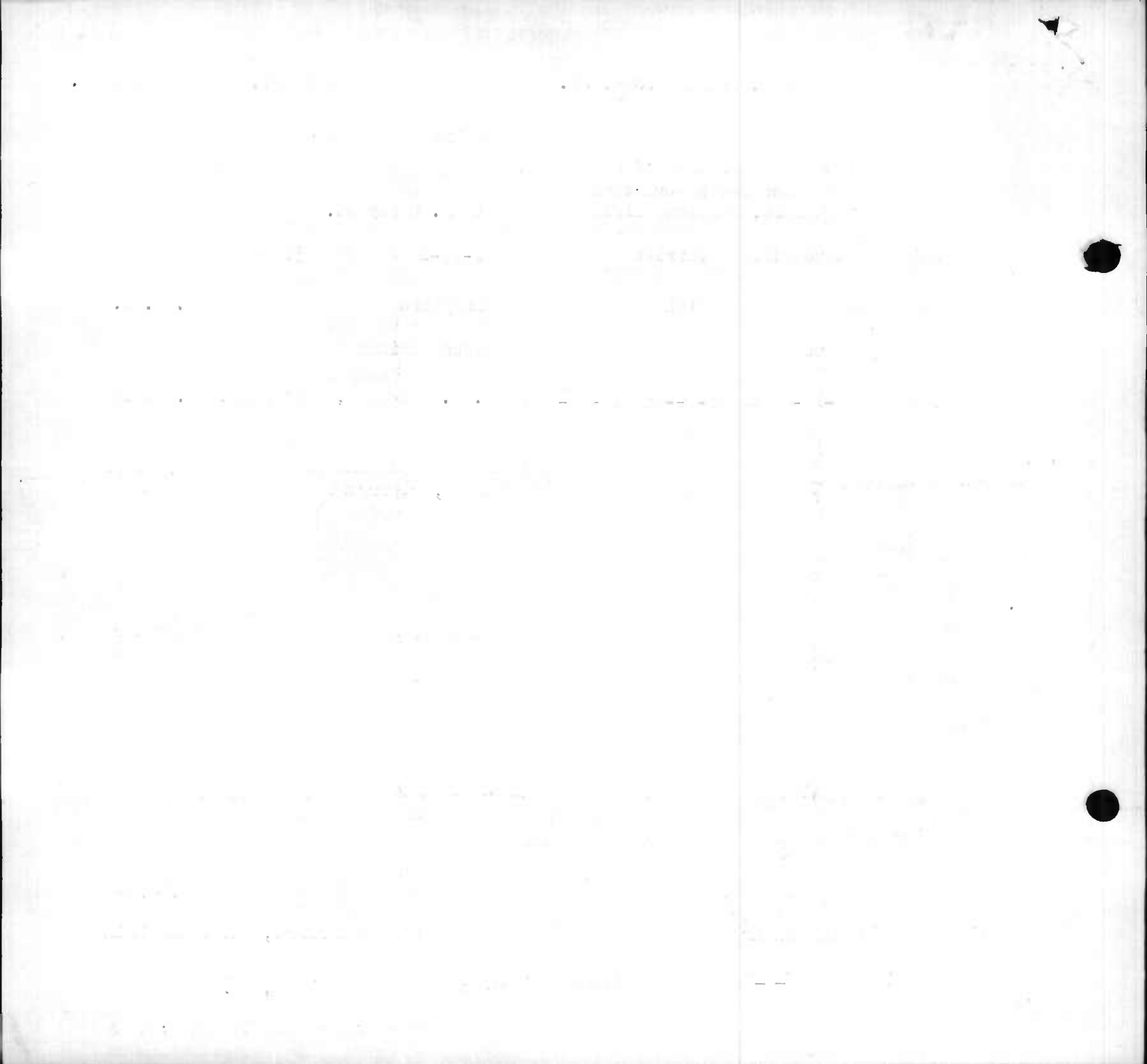
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | |
|---|--|-----------------------------|--|--|--|---|--|--|--|--|--|-----------------------|--|--|--|--|--|
| BIRTH NO. 66 04483 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 04483 | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) REKUS, Anthony John, Jr. | | | | | 2. DATE AND HOUR OF DEATH
April 27, 1966 9:50 P. | | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
18 N. Carey St. | | | | | | | | | | | | |
| 5. SEX
Male | | 6. RACE
Caucasian | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
1-29-14 | | 9. AGE (In years last birthday)
52 | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bartender | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Unk | | | | | 11. BIRTHPLACE (State or foreign country)
Maryland | | | | | | | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | 13. FATHER'S NAME
Anthony Rekus | | | | | 14. MOTHER'S MAIDEN NAME
Anna Dobinas | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 3-20-44 to 12-20-45 | | | | | 16. SOCIAL SECURITY NO.
217-09-5726 | | | | | 17. INFORMANT Records ADDRESS
V. A. Hospital, Baltimore, Md. 21218 | | | | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Epidermoid Carcinoma of the Larynx, recurrent
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Pulmonary Tuberculosis | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
7 years | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | | | | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No)
No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (X) (this hospital) attended the deceased from January 27 19 66 to April 27 19 66 , that (X) (we) last saw the deceased alive on April 27 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE

MARYLOU McIHANEY | | | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
4/28/66 | | | |
| 23C. PHYSICIAN'S NAME (Type)
MARYLOU McIHANEY | | | | | | | | | | 23D. ADDRESS
M.D. VA Hospital Baltimore, Maryland 21218 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | 24B. DATE
5-2-1966 | | 24C. NAME OF CEMETERY OR CREMATORY
Baltimore National cem | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1966 | | | | | 25B. NAME OF REGISTRAR
R. E. Johnson | | | | | 25C. FUNERAL DIRECTOR ADDRESS
Thomas J Kenny Inc 1600 Hopkins St | | | | | | | |



R-563

1

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 44484

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Joseph H. Reinhardt, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

4/28/66

11:30 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

705 S. Dallas St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

705 S. Dallas St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

10-11-1914

9. AGE (In years
last birthday)

52 51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MOLDER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOSEPH REINHARDT, SR.

14. MOTHER'S MAIDEN NAME

MARGARET GIBSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

YES

W W II

16. SOCIAL
SECURITY NO.

190-10-6726

17. INFORMANT

ADDRESS

OLIVE KIRBY, WASHINGTON, D. C.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Bilateral bronchopneumonia
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Fatty alteration of liver

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/29/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

5-3-66

23C. NAME OF CEMETERY or CREMATORY

MONONGAHELA CEMETERY M

23D. LOCATION

(City, town, or county)

(State)

MONONGAHELA, PENNSYLVANIA

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

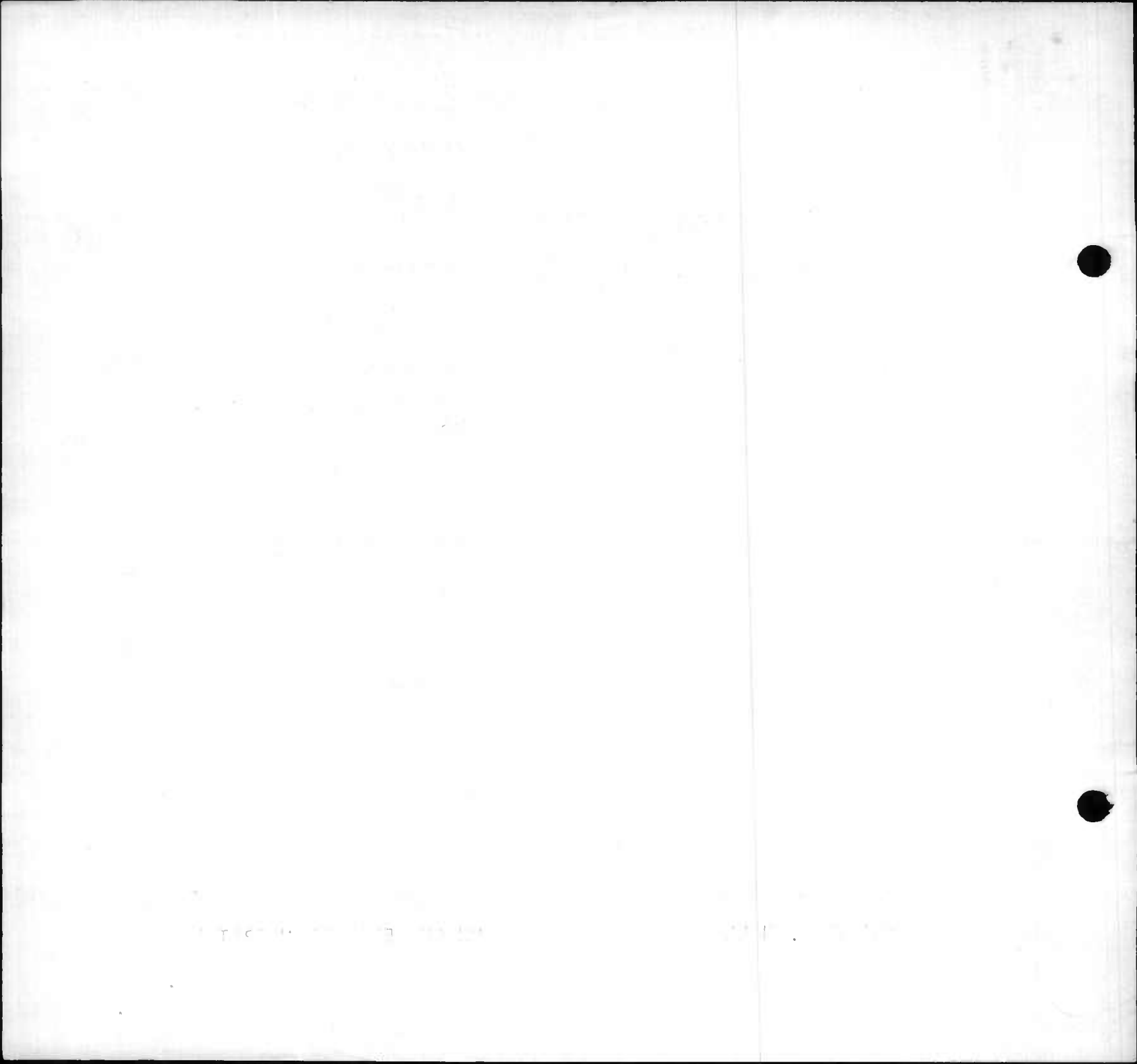
HUBBARD FUNERAL HOME, 4107 WILKENS AVE. #29

WALLER FORGE
FACILITY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

| | | | | | |
|---|------------------|--|--------------------------------|--|-----------------------------|
| BIRTH NO. 66 04485 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04485 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Theresa Agnes Lamb</i> | | | |
| 2. DATE AND HOUR OF DEATH <i>5/2/66 9:25 A.M.</i> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>26-03</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hosp</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>3240 Kentucky Ave</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i> | 8. DATE OF BIRTH <i>2/6/93</i> | 9. AGE (In years last birthday) <i>73</i> | 10. Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <i>William C Deekley</i> | | | |
| 14. MOTHER'S MAIDEN NAME <i>Mary Streckfus</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Thomas E. Lamb, husband, above</i> | | | |
| 18. <i>422.1 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>Cerebrovascular Accident</i>
<i>Arteriosclerotic Cardiovascular Disease</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>no</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4/22</i> 19 <i>66</i> to <i>5/2</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>5/2</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Donald A. Hall</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>5/2/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>DONALD A. HALL</i> | | 23D. ADDRESS <i>UNION MEMORIAL HOSPITAL</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>5/5/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National Cem</i> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAY 3 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fabela</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Schimunek Funeral Home, Inc. 3331 Brehms Lane</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

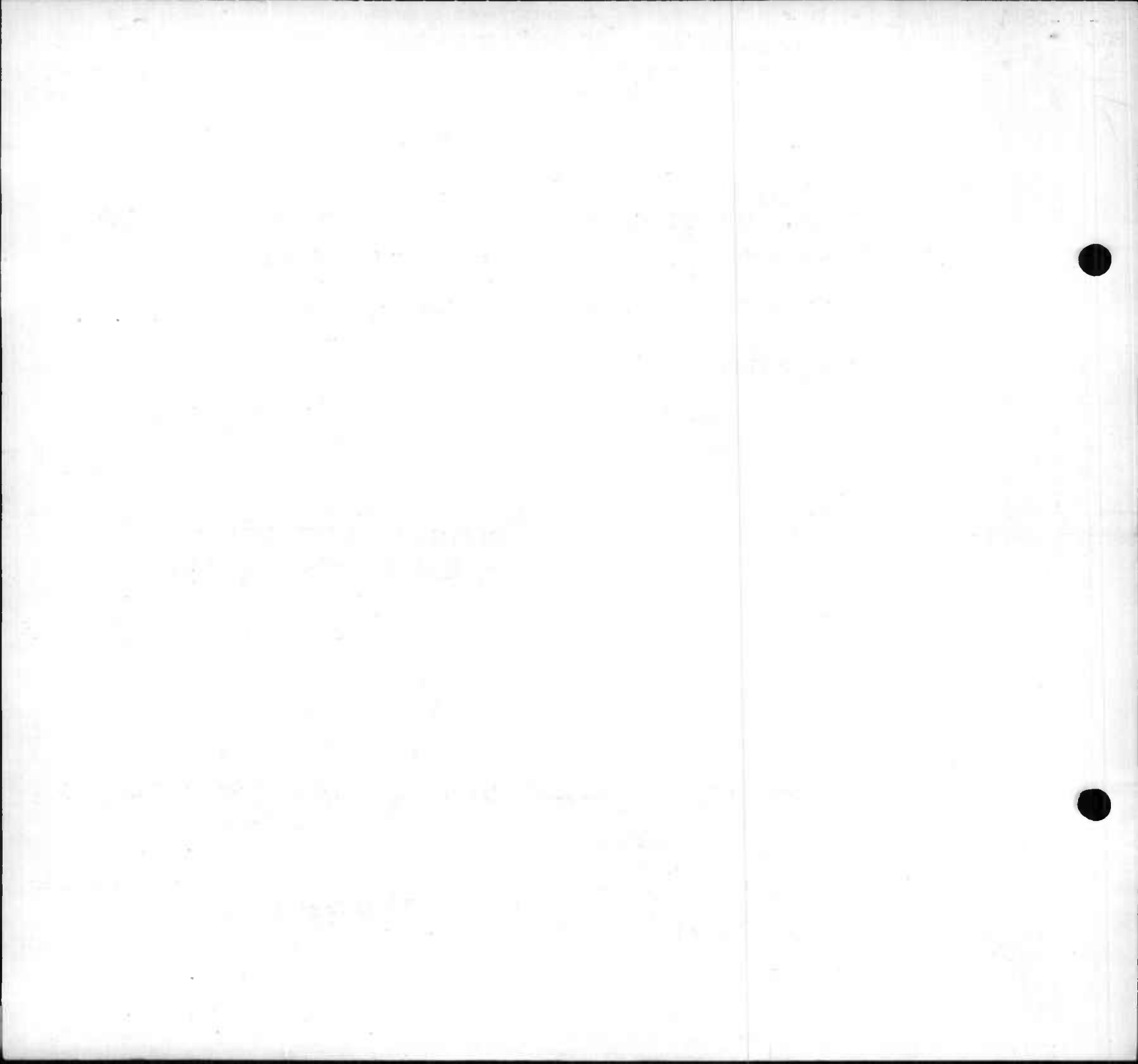
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>66 04486</u> | |
|--|-------------------|--|---------------------------------|--|--|--|-----------------------|
| BIRTH NO. <u>66 04486</u> | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED <u>OSENBERG, Charles E.</u> | | | | 2. DATE AND HOUR OF DEATH <u>4-30-66</u> <u>6⁵⁰</u> P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> | | | | A. STATE <u>MARYLAND</u> B. COUNTY <u>8-01</u> | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>2822, MAYFIELD AVE.</u> | | | |
| 5. SEX <u>M.</u> | 6. RACE <u>W.</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>12-6-79</u> | 9. AGE (In years last birthday) <u>86</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales RETIRED</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Welsh Constr. Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>WILLIAM H. OSENBURG</u> | | | | 14. MOTHER'S MAIDEN NAME <u>WEAVER</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u> | | | | 16. SOCIAL SECURITY NO. <u>219-16-6937</u> | | 17. INFORMANT <u>Rose M. Forster Osenburg</u> ADDRESS <u>same</u> | |
| 18. <u>153.31</u> | | | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) <u>METASTATIC CARCINOMA 2 YEARS</u> | | | |
| (This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.) | | | | (B) <u>PRIMARY - Ca. of sigmoid</u> | | | |
| ANTECEDENT CAUSES | | | | (C) <u>COLON</u> | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>PROCTOSCOPY</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca. of sigmoid colon</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>April 20th 1966</u> to <u>April 26th 1966</u> , that (I) (we) last saw the deceased alive on <u>4-30-66</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Milton C. Lang</u> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>4/30/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>MILTON C. LANG</u>
<u>Milton C. Lang</u> | | | | 23D. ADDRESS <u>Union Memorial Hospital</u>
<u>28 Union Memorial Hospital Bld.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>5/4/66</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u>
<u>3331 Brehms Lane</u> | | | |

WILLIAM HENRY ALBRIGHT

WILLIAM C. LANG

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04487 | |
|---|--|--|--|
| BIRTH NO. 5-650 | | M.E. CASE NO. 7786-04487 | |
| 1. NAME OF DECEASED (Type or Print) (or Margaret) Marjorie SERIANNI | | 2. DATE AND HOUR OF DEATH 4/30/66 11:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| | | D. STREET ADDRESS (If rural, give location) 2640 ASHLAND AVE. 21205 | |
| 5. SEX Female | 6. RACE CAUCASIAN | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 4-1-88 |
| | | 9. AGE (In years last birthday) 78 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY at home | 11. BIRTHPLACE (State or foreign country) Maryland, Baltimore |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Pasquale Alvigi | |
| 14. MOTHER'S MAIDEN NAME Theresa ? | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Frank Serianni, husband, above | |
| 18. 795-5-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH (A) Anemia (B) Chronic infection & decubiti & kidneys (C) & (2) lowest hip nail | |
| INTERVAL BETWEEN ONSET AND DEATH 2 wks | | 2 months | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Parkinsonism, Rhtd arthritis 10 years | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/7/66 to 4/30/66, that (I) (we) last saw the deceased alive on 4/30/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE James Sam Lowie M.D. | | 23B. DATE SIGNED 4/30/66 | |
| 23C. PHYSICIAN'S NAME (Type) JAMES SAM LOWIE M.D. | | 23D. ADDRESS 4940 Eastern Avenue Balt. City Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 5/3/66 | 24C. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 3 1966 | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601 E. Madison St. | |



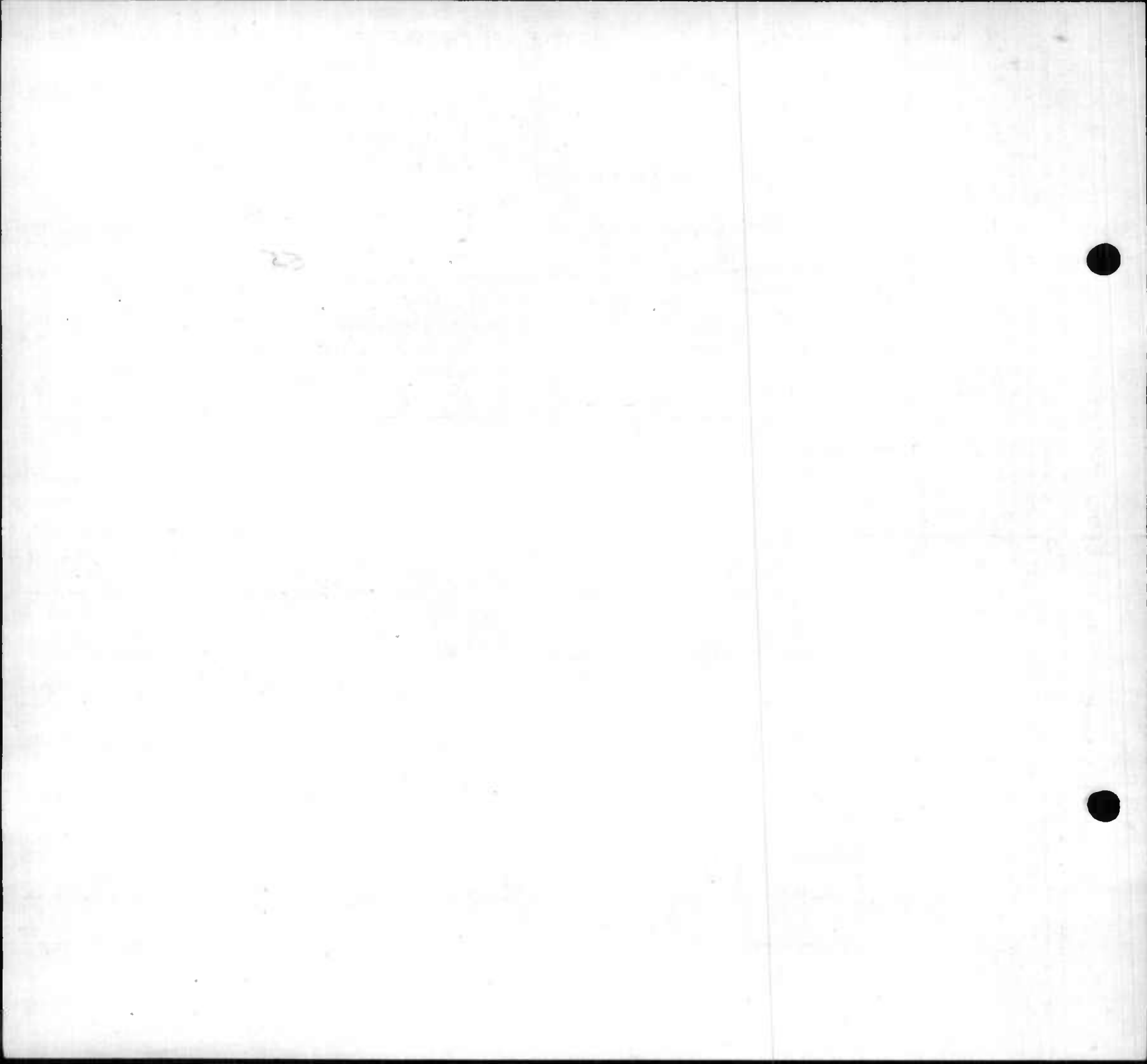
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|---|---------------------|---|--|--|--|--|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>66-14488</u> | | | | | |
| BIRTH NO. <u>66-14488</u> | | M.E. CASE NO. | | | 1. NAME OF DECEASED
(Type or Print) <u>Michael Frank Stremensky</u> | | | 2. DATE AND HOUR OF DEATH
<u>3:50 pm</u> <u>4/29/66</u> M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Union Memorial Hospital (DOA)</u>
<u>XXXXXX</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY <u>5-01</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u>
D. STREET ADDRESS (If rural, give location)
<u>2614 Erdman Ave</u> | | | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Married</u> | | 8. DATE OF BIRTH
<u>Dec. 8, 1910</u> | 9. AGE (in years last birthday)
<u>55</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Foreman Steel Worker</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Beth. Steel</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Coaldale, Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | |
| 13. FATHER'S NAME
<u>Frank Strmensky</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Jakubec</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>166-03-9792</u> | | 17. INFORMANT
<u>Chart - UMH</u> | | | ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<u>420.1 I</u>
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH
(A) <u>Acute Myocardial Infarction ?</u>
DUE TO
(B) _____
DUE TO
(C) _____ | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<u>-</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
<u>-</u> | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
<u>-</u> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<u>-</u> | | | | | | |
| 22. I certify that <u>4</u> (this hospital) attended the deceased from <u>4</u> 19 <u>66</u> to <u>4-26</u> 19 <u>66</u> , that <u>4</u> (we) last saw the deceased alive on <u>4-26</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>4</u> (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE
<u>Lawrence J. Lieberman</u> M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
<u>4/29/66</u> | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS
M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>5/2/66</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Oak Lawn Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 3 1966</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Fisher, MD</u> | | | 25C. FUNERAL DIRECTOR ADDRESS
<u>Schimunek Funeral Home, Inc.</u>
<u>3331 Brehms Lane</u> | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04489 | |
|--|---------------------|--|--|--|---|
| BIRTH NO. 66 04489 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) LUTZ, BERTHA | | 2. DATE AND HOUR OF DEATH
5.2, 1966 4 50 AM. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE BALTIMORE 21213
B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
UNION MEMORIAL HOSPITAL
BALTIMORE; 18 | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 26-23 | | |
| | | | D. STREET ADDRESS (If rural, give location)
3124 KENTUCKY AVE | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED (specify) | 8. DATE OF BIRTH
11.4.90 | 9. AGE (In years last birthday)
75 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
at home | | 11. BIRTHPLACE (State or foreign country)
MARYLAND Baltimore | |
| 12. CITIZEN OF WHAT COUNTRY?
AMERICAN | | 13. FATHER'S NAME
DANIEL HYLOCK | | | |
| 14. MOTHER'S MAIDEN NAME
MARGARET | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
- | | | |
| 16. SOCIAL SECURITY NO.
212-10-5525 | | 17. INFORMANT
DAUGHTER ADDRESS
SAME | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
332 XI | | | CAUSE OF DEATH
(A) CEREBROVASCULAR THROMBOSIS + 3 WEEKS
(B) ARTERIOSCLEROSIS DIFFUSE
(C) PNEUMONIA | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
none | | |
| 19A. DATE OF OPERATION
none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | 20A. AUTOPSY? (Yes or No)
- | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
- | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
- | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)
no | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
- | |
| 22. I certify that (I) (this hospital) attended the deceased from 4.19 1966 to 5.2 1966 , that (I) (we) last saw the deceased alive on 5.2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Danuta Daniec | | | | 23B. DATE SIGNED
5.2. 66 | |
| 23C. PHYSICIAN'S NAME (Type)
DANUTA DANIEC | | 23D. ADDRESS
THE UNION MEMORIAL HOSPITAL
UNION MEMORIAL HOSPITAL, BALTIMORE 18 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/5/66 | | 24C. NAME of CEMETERY or CREMATORY
Oak Lawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1966 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Schimunek | | 25C. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
3331 Brehms Lane | | | |

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>86-04490</u> | |
|--|---------------------|---|------------------------------------|--|----------------------------|--|-----------------------------|
| BIRTH NO. <u>66-10012 66 04490</u> | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>GRIEB Charles</u> | | | | 2. DATE AND HOUR OF DEATH
<u>4-28-66</u> <u>10⁴⁰</u> A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>MERCY HOSPITAL</u> | | | | A. STATE <u>MARYLAND</u>
B. COUNTY <u>Baltimore</u> | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>5615 KENWOOD AVE</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>NEVER MARRIED</u> | 8. DATE OF BIRTH
<u>4-27-66</u> | 9. AGE (In years last birthday)
<u>30 hrs 40 min</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>None</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>None</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA.</u> | |
| 13. FATHER'S NAME
<u>CHARLES E. GRIEB</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>NANCY M. WALTER</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<u>Charles E. Grieb 5615 Kenwood Ave</u> | | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>CNS anoxia</u> | | | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) <u>congestive heart failure</u> | | | |
| | | | | (C) <u>aortic stenosis (?)</u> | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>Minimal pneumothorax</u> | | | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>4-27</u> 19 <u>66</u> to <u>4-28</u> 19 <u>66</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>4-28</u> 19 <u>66</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Perry S. Shelton</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>4-29-66</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Perry S. Shelton</u> | | | | 23D. ADDRESS
<u>Mercy Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4-29-1966</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Gardens of Faith Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore Co. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 3 1966</u> | | 25B. NAME OF REGISTRAR
<u>R. E. Taylor</u> | | 25C. FUNERAL DIRECTOR
<u>Lassahn Funeral Home</u> | | ADDRESS
<u>7401 Belair Road</u> | |

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FUNERAL DIRECTOR: IMPORTANT

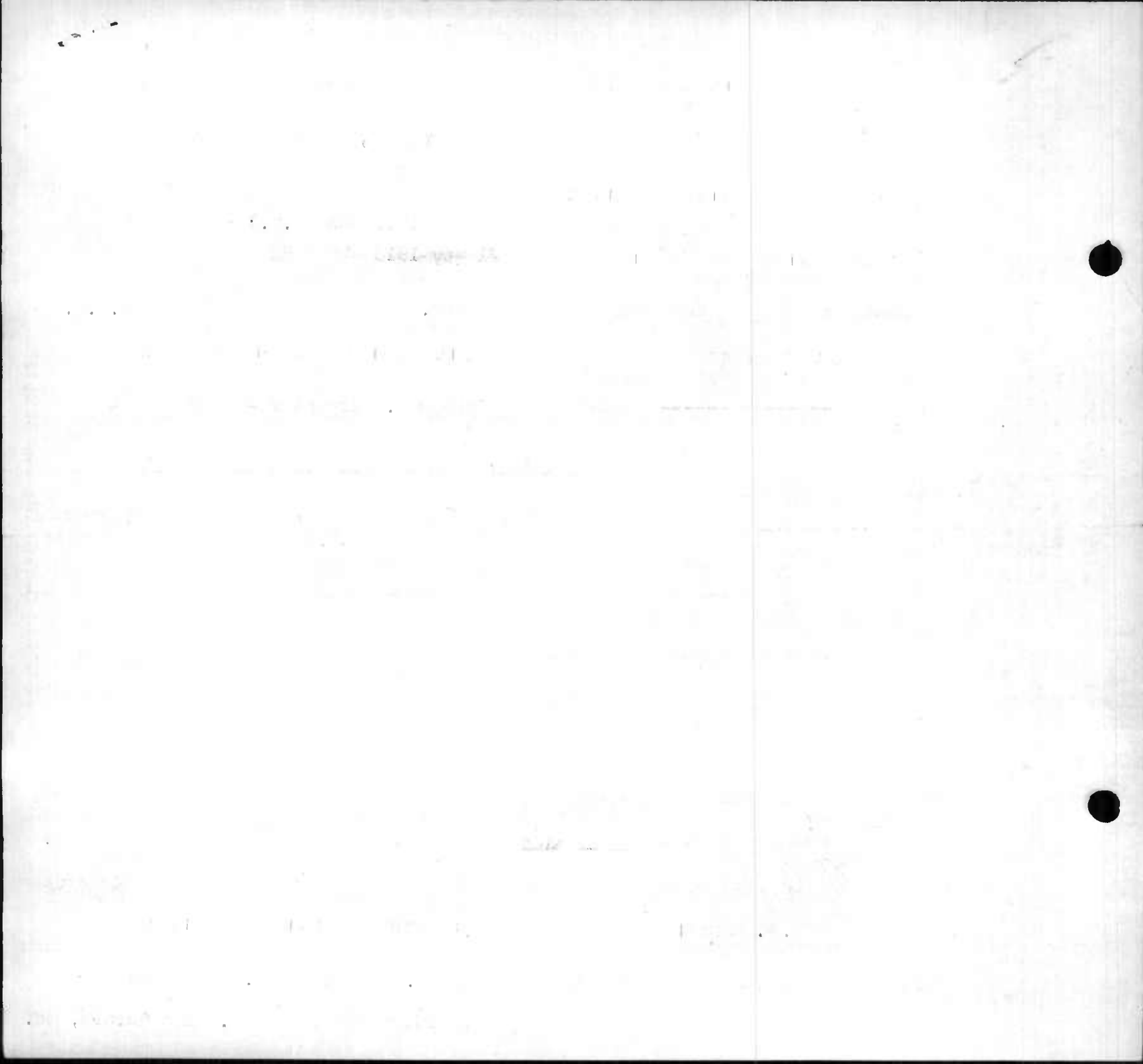
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|------------------|---|---------------------------------------|--|--|---|--|---|--|
| 66 04491 CERTIFICATE OF DEATH | | | | | Registered No. 66 04491 | | | | |
| BIRTH NO. 66 04491 | | | | | 2. DATE AND HOUR OF DEATH
4-30-66 4:15 P.M. | | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)
MARJORIE CARPENTER | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
THE JOHNS HOPKINS HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND, ANNE ARUNDEL
C. CITY OR TOWN (If outside city limits, write RURAL and give township) HARMAN
D. STREET ADDRESS (If rural, give location) (Harmans P.O.) | | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
21 May 1913 | 9. AGE (in years)
52 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 11. BIRTHPLACE (State or foreign country)
Penn. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
CHARLES BERGENER | | | | | 14. MOTHER'S MAIDEN NAME
WILHELMINA PETERINAN | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT ADDRESS
Joseph E. Carpenter - Same as # 4 | | | | |
| 18. 292.4 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | CAUSE OF DEATH
(A) GRAM NEGATIVE SEPSIS
DUE TO
(B) APLASTIC ANEMIA
DUE TO
(C) | | | INTERVAL BETWEEN ONSET AND DEATH
3 days
11 months | |
| | | | | | | | | | |
| | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
NONE | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 27 1966 to APRIL 30 1966, that (I) (we) last saw the deceased alive on APRIL 30 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (what) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
M. A. Dennis | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
April 30, 1966 | | |
| 23C. PHYSICIAN'S NAME (Type)
M.A. DENNIS | | | | | 23D. ADDRESS
M.D. THE JOHNS HOPKINS HOSPITAL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/4/1966 | | 24C. NAME of CEMETERY or CREMATORY
Meadowridge Memorial Pk. | | 24D. LOCATION (City, town, or county) (State)
Howard Co., Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1966 | | | 25B. NAME OF REGISTRAR
R. E. Smith | | 25C. FUNERAL DIRECTOR ADDRESS
Singleton Funeral Home, Glen Burnie, Md. | | | | |

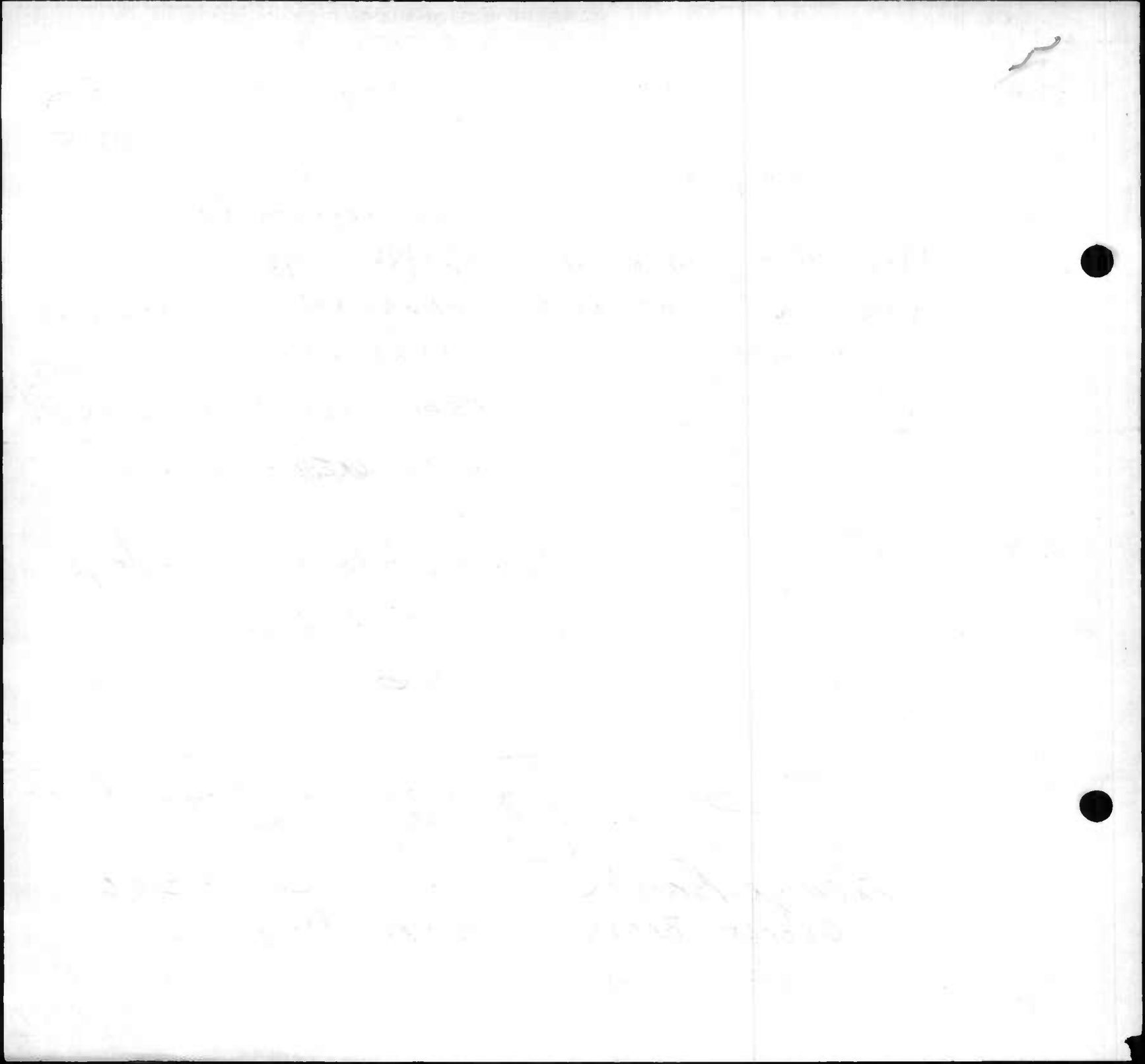


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04492 | |
|--|-------------------------|---|--|---|---|
| BIRTH NO. 66 04492 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) BUCHMAN, DANIEL | | | 2. DATE AND HOUR OF DEATH
May 2nd 1966 8:05 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
42 SINAI HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY 21215
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE, M.D. 217-20
D. STREET ADDRESS (If rural, give location)
3803 LABYRINTH RD. | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
UNKNOWN | 8. DATE OF BIRTH
3/26/88 | 9. AGE (In years last birthday)
78 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
UNKNOWN | | 10B. KIND OF BUSINESS OR INDUSTRY
UNKNOWN | | 11. BIRTHPLACE (State or foreign country)
UNKNOWN | |
| 12. CITIZEN OF WHAT COUNTRY?
UNKNOWN | | | 13. FATHER'S NAME
UNKNOWN | | |
| 14. MOTHER'S MAIDEN NAME
UNKNOWN | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) no | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Mc Henry Buchman ADDRESS 3803 Rd | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
3321 | | | CAUSE OF DEATH
(A) Atherosclerotic Coronary Arteriosclerosis
(B) Cerebral Infarction
(C) 6 days | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Atrial Fibrillation | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION
None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
No | | 21B. WHERE DID INJURY OCCUR? | | 21C. HOW DID INJURY OCCUR? | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 30 19 66 to May 2nd 19 66 , that (I) (we) last saw the deceased alive on May 2nd 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE George Banks M.D. | | | | 23B. DATE SIGNED 5/2/66 | |
| 23C. PHYSICIAN'S NAME (Type) GEORGE BANKS M.D. | | | | 23D. ADDRESS SINAI HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5/3/66 | | 24C. NAME OF CEMETERY or CREMATORY Pelash Tikhrah | |
| 24D. LOCATION (City, town, or county) (State) Piedmont Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAY 3 1966 | | | |
| 25B. NAME OF REGISTRAR Dr. E. E. Taylor | | 25C. FUNERAL DIRECTOR Mc Lennson & Son - 600 West. Rd. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--|--|--|---|---|---|--|-----------------------------------|---|
| CERTIFICATE OF DEATH | | | | | Registered No. 66 04493 | | | | |
| BIRTH NO.
66 04493 | | M.E. CASE NO. | | | 1. NAME OF DECEASED
(Type or Print)
MATILDA BRAITMAN | | 2. DATE AND HOUR OF DEATH
5/2/66 8:30 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
SINAI HOSP. of BALTO | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore | | | | |
| 5. SEX FEMALE | | | | | 6. RACE CAUCASIAN | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
NEVER MARRIED | | 8. DATE OF BIRTH
3-14-93 |
| 9. AGE (In years last birthday)
73 | | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SALESWOMAN | | | 10B. KIND OF BUSINESS OR INDUSTRY
DEPT. STORE | | 11. BIRTHPLACE (State or foreign country)
ROMANIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
LOUIS BRAITMAN | | | | | 14. MOTHER'S MAIDEN NAME
ELLA COHEN | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
SAMUEL BRAITMAN | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
BILIARY CIRRHOSIS | | | | | INTERVAL BETWEEN ONSET AND DEATH
> 4 YRS | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
CHRONIC ACTIVE HEPATITIS | | | | | > 6 YRS | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
NONE | | | | | | | | | |
| 19A. DATE OF OPERATION
4/18/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
OPEN LIVER BIOPSY | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
NONE | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
NO | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NO | | | | | |
| 21D. TIME OF INJURY (APPROX.)
--- | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
--- | | | | | |
| 22. I certify that she (this hospital) attended the deceased from 3/25 19 66 to 5/2 19 66 that we lost saw the deceased alive on 5/2 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. we (We) (did) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<i>Joseph S. Weinstock</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
5/2/66 | |
| 23C. PHYSICIAN'S NAME (Print)
Joseph S. Weinstock | | | | | 23D. ADDRESS
Sinai Hospital | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
May 3, 1966 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore Hebrew | | | 24D. LOCATION (City, town, or county) (State)
2100 Belair Road | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1966 | | 25B. NAME OF REGISTRAR
R. E. Taylor | | | 25C. FUNERAL DIRECTOR
Sol Levinson & Bros 6010 Reisterstown Rd. | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | |
|--|--|-------------------------|--|---|----------------------|---|--|--|--|--|--|--|--|-----------------------------------|--|
| BIRTH NO. 66 04494 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 04494 | | | | | |
| 1. NAME OF DECEASED
(Type or Print) SAPP LOUIS | | | | | | | | | | 2. DATE AND HOUR OF DEATH
5/1/66 5:00 P M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
JOHNS HOPKINS Hospital | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
3629 PASKIN PLACE - apt 6A | | | | | |
| 5. SEX
MALE | | 6. RACE
WHITE | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
3-22-96 | | 9. AGE (In years last birthday)
70 | | 10. Under 1 Yr. Months: Days | | 11. Under 24 Hrs. Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Retail | | | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
ABRAHAM SAPP | | | | | | | | | | 14. MOTHER'S MAIDEN NAME
Miriam Brown | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
215-10-8156 | | 17. INFORMANT
Mrs. Sarah Sapp - 3629 Paskin Place | | | | ADDRESS | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
Respiratory Arrest | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
mins | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | (B) Sjogren's Syndrome years | | | | | |
| | | | | | | | | | | (C) Chronic Lymphatic Leukemia years | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | Encephalitis (R) eye weeks | | | | | |
| 19A. DATE OF OPERATION
0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that W (this hospital) attended the deceased from 4/27 19 66 to 5/1 19 66 , that W (we) last saw the deceased alive on 5/1 19 66 and that in W (our) opinion death occurred on the date and hour and from the causes stated above. W (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 23A. SIGNATURE
W. H. Spencer III | | | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
5/1/66 | |
| 23C. PHYSICIAN'S NAME (Type)
W. H. SPENCER 3RD | | | | | | | | | | M.D. 23D. ADDRESS
JH H | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | 24B. DATE
May 2/66 | | 24C. NAME OF CEMETERY or CREMATORY
Hebrew Young Men | | | | 24D. LOCATION (City, town, or county) (State)
Woodlawn, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1966 | | | | 25B. NAME OF REGISTRAR
R. E. Farber | | | | 25C. FUNERAL DIRECTOR
Sol Levinson & Bros, Inc. | | | | ADDRESS
6010 Reisterstown Rd | | | |

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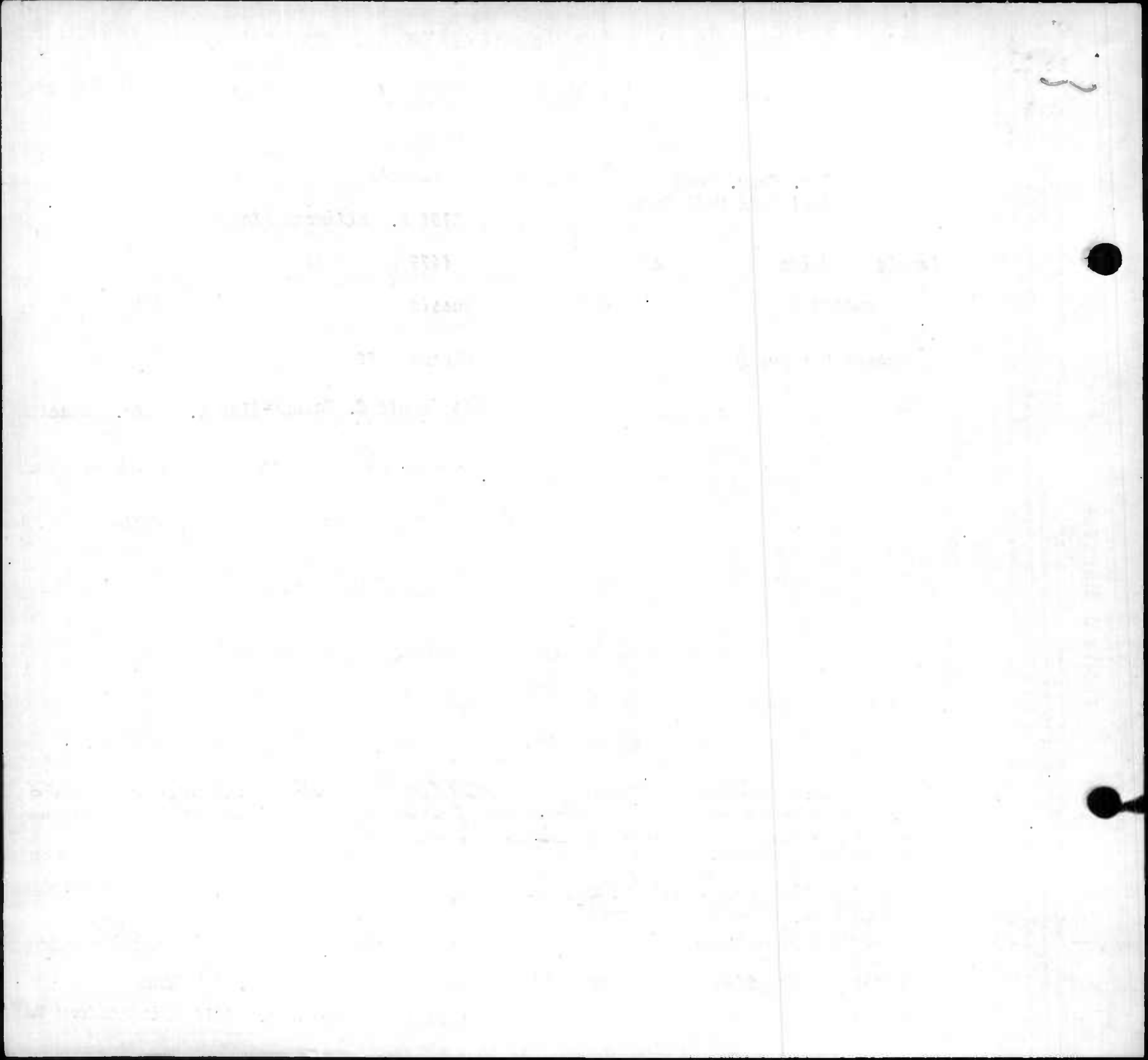
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 04495 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04495 | |
|--|-------------------------|---|---------------------------------|---|----------------------------|---|-----------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Rebecca Palees</u> | | | | 2. DATE AND HOUR OF DEATH
<u>May 1-1966</u> <u>4:30 A.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Jew. Conv. Home</u>
<u>4601 Pall Mall Road</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY <u>6-03</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u>
D. STREET ADDRESS (If rural, give location)
<u>2138 E. Baltimore Street</u> | | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Widow</u> | 8. DATE OF BIRTH
<u>1879</u> | 9. AGE (In years last birthday)
<u>86</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>At Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Russia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Michael Moskovsky</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Cherna ??</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Miss Jennie C. Palees-2138 E. Balto. Street</u> | | ADDRESS | |
| 18. <u>422.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Myocardial Insufficiency</u>
<u>Arteriosclerosis</u> | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO
<u>unknown</u>
<u>unknown</u> | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/18</u> 19 <u>64</u> to <u>May 1</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 1</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>David I. Miller</u> M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>May 1-1966</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>David I. Miller</u> M.D. | | | | 23D. ADDRESS
<u>Sinai Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>May 2/66</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Beth Isaac Adath Israel</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 3 1966</u> | | 25B. NAME OF REGISTRAR
<u>R. E. Johnson</u> | | 25C. FUNERAL DIRECTOR
<u>Sol Levinson & Bros Inc.</u> | | ADDRESS
<u>6010 Ruisterstown Rd</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

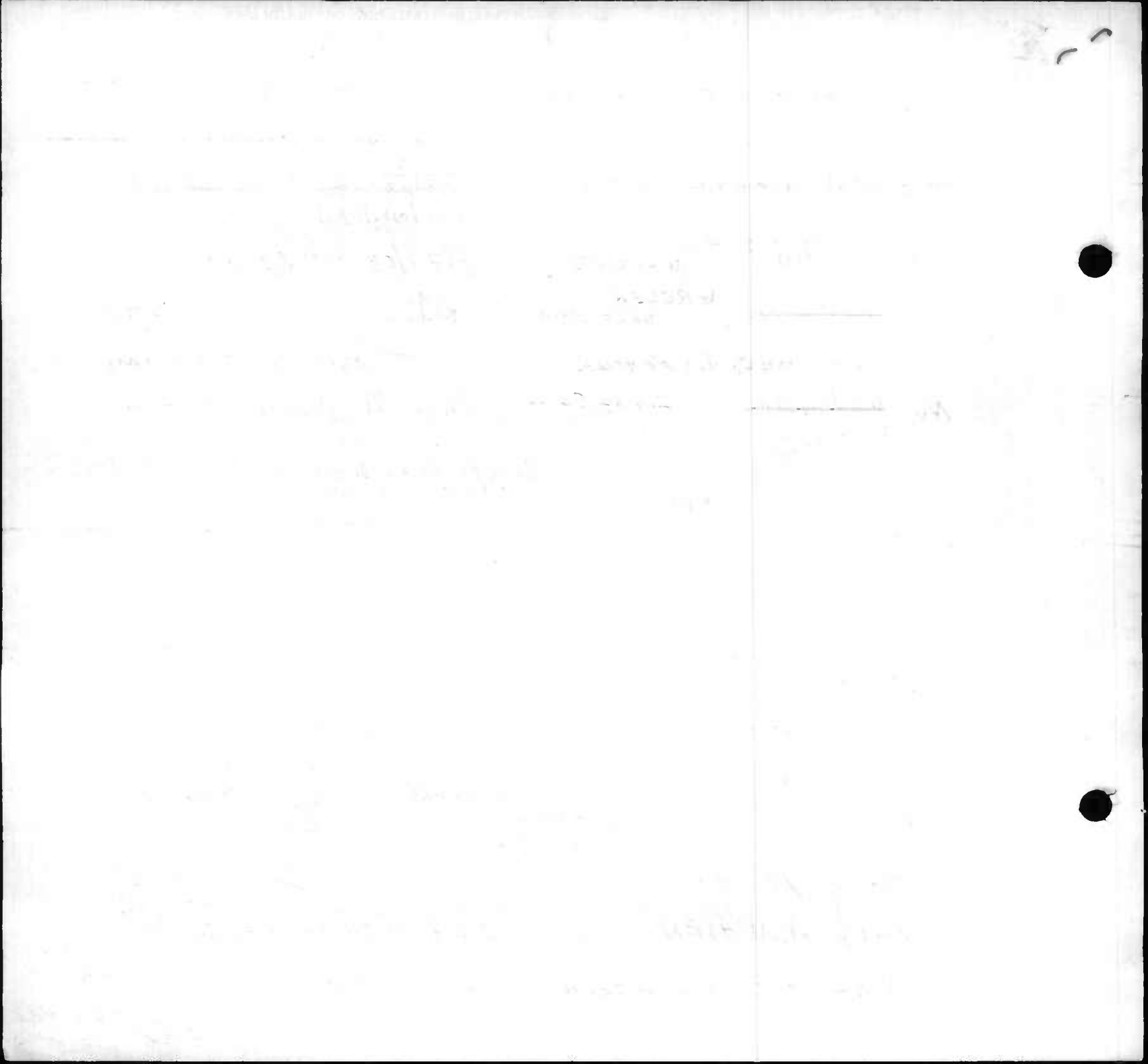
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 04496 | |
|--|-------------------------|--|---|---|---|
| BIRTH NO. 66 04496 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) MONROE COHEN | | 2. DATE AND HOUR OF DEATH
SUN. MAY 1, 1966 8 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY 27-18 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Mt. Sinai Nursing Home
4613 Park Heights Avenue | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
3408 Hayward Avenue | |
| | | | | D. STREET ADDRESS (If rural, give location)
Baltimore, Maryland | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH | 9. AGE (In years last birthday)
76 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY
? | | 11. BIRTHPLACE (State or foreign country)
Americas, Georgia | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | 13. FATHER'S NAME
Unknown | | |
| 14. MOTHER'S MAIDEN NAME
Unknown | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS
Mrs Goldie Cohen- 3408 Hayward Avenue | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Cerebral hemorrhage
DUE TO
Arteriosclerotic cardiovascular disease | | | | INTERVAL BETWEEN ONSET AND DEATH
1 day
Several years | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from April 29 1966 to May 1 1966, that (I) (we) last saw the deceased alive on April 29 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Seymour H. Rubin M.D. | | | | 23B. DATE SIGNED
5/2/66 | |
| 23C. PHYSICIAN'S NAME (Type)
Seymour H. Rubin M.D. | | | | 23D. ADDRESS
5715 Park Heights Ave | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
May 2, 1966 | | 24C. NAME OF CEMETERY or CREMATORY
Lorraine | |
| | | 24D. LOCATION (City, town, or county) (State)
Woodlawn, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1966 | | 25B. NAME OF REGISTRAR
Sol Levinson & Bros Inc. | | 25C. FUNERAL DIRECTOR ADDRESS
6010 Reisterstown Rd | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|---------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 04497 | |
| BIRTH NO. 66 04497 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) Creamer Charles A. | | 2. DATE AND HOUR OF DEATH
4-28-66 8 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
SINAI HOSP OF BALTO. | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Balto. Pikesville 8 Md 5300
D. STREET ADDRESS (If rural, give location)
Orchard Rd | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
2/27/03 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
unknown | | 10B. KIND OF BUSINESS OR INDUSTRY
GROGER
SELF EMP. | 9. AGE (In years lost birthday)
63 |
| 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
GEO. J. CREAMER | | 14. MOTHER'S MAIDEN NAME
KATHERINE KRAMER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No unknown | | 16. SOCIAL SECURITY NO.
219 32 0571 | |
| 17. INFORMANT
Harry M. Walen | | ADDRESS
SINAI HOSP | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cerebrovascular accident
DUE TO (A) _____
(B) _____
(C) _____
INTERVAL BETWEEN ONSET AND DEATH
20 days | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
none | |
| 20A. AUTOPSY? (Yes or No)
none | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
none | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
none | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
none | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
none | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)
none | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
none | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-8-66 19 to 4-28-1966 , that (I) (we) last saw the deceased alive on 4-27-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Harry M. Walen | | 23B. DATE SIGNED
4-28-66 | |
| 23C. PHYSICIAN'S NAME (Type)
HARRY M. WALEN | | 23D. ADDRESS
SINAI HOSP OF BALTO. | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5/2/66 | |
| 24C. NAME OF CEMETERY or CREMATORY
MEADOWRIDGE | | 24D. LOCATION (City, town, or county) (State)
HOWARD CO. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1966 | | 25B. NAME OF REGISTRAR
E. S. MACNABB | |
| 25C. FUNERAL DIRECTOR
E. S. MACNABB | | ADDRESS
301 FREDERICK RD 21228 | |



E-6510

BALTIMORE CITY HEALTH DEPARTMENT

86 04488

BIRTH NO.

66 04488

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Irvin Crane

2. DATE AND HOUR PRONOUNCED DEAD

4/29/66 3:22 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

4511 Park Heights Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4511 Park Heights Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

DIVORCED

8. DATE OF BIRTH

June 14, 1911

9. AGE (in years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Furniture

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Louis Crane

14. MOTHER'S MAIDEN NAME

Rose

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W. W. 11

16. SOCIAL
SECURITY NO.

220-05-4312

17. INFORMANT

ADDRESS

Mrs. Freda Emmer- 5811 Key Avenue

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Barbiturate poisoning
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

4511 Park Heights Ave.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

4 ? 66 ?

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

ingested overdose of barbiturates

22.

I certify that I held an Inquiry ☒ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/30/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

May 1/66

23C. NAME of CEMETERY or CREMATORY

Har Sinai

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 3 1966

24B. NAME OF REGISTRAR

Robert E. Johnson

24C. FUNERAL DIRECTOR

Sol Levinson & Bros Inc. 6010 Reisterstown
Road

ADDRESS

511-25-01

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 04499 | | | | CITY HEALTH DEPARTMENT | | Registered No. 66 04499 | |
|---|---------------------|--|---|--|---|---|--|
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Fanny Eiman</i> | | | | 2. DATE AND HOUR OF DEATH
<i>April 30, 1966 11:04 A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Simon Hosp Baltimore</i> | | | | A. STATE <i>Maryland</i> B. COUNTY <i>27-19</i> | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<i>5827 Jonquil Avenue</i> | | | |
| | | | | ***** | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>W</i> | 8. DATE OF BIRTH
<i>July 31, 1899</i> | 9. AGE (In years last birthday)
<i>66</i> | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>at home</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore, Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> |
| 13. FATHER'S NAME
<i>Louis Sollins</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Sophie Lieberman</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<i>Mrs. Jean Satsky- 7923 Winterset Ave.</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<i>420.14 1260X</i> | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) DUE TO
<i>Myocardial Infarction</i> | | <i>12 hours</i> | |
| | | | | (B) DUE TO
<i>Arteriosclerotic Cardiovascular -</i> | | <i>10 years</i> | |
| | | | | (C) DUE TO
<i>chronic Heart Disease</i> | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<i>II</i> | | | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 19A. DATE OF OPERATION
<i>0</i> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>April 29</i> 19 <i>66</i> to <i>April 30</i> (19 <i>66</i>) that (I) (we) last saw the deceased alive on <i>April 30</i> (19 <i>66</i>) and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Terrence M. Himelefard</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>April 30, 1966</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>TERRENCE M. HIMELEFARD</i> | | | | 23D. ADDRESS
<i>Simon Hosp</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>5/1/66</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Ohel Yakov</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>MAY 3 1966</i> | | | | 25B. NAME OF REGISTRAR
<i>Robert E. Faller</i> | | 25C. FUNERAL DIRECTOR ADDRESS
<i>Sol Levinson & Bros Inc. 6010 Reisterstown Rd</i> | |

2

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

LABORATORY OF ORGANIC CHEMISTRY

CHICAGO, ILLINOIS

RECEIVED JANUARY 10, 1955

RECEIVED JANUARY 10, 1955

68 04500

BALTIMORE CITY HEALTH DEPARTMENT

68 04500

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

James H. Ottley

2. DATE AND HOUR PRONOUNCED DEAD

4/30/66 7:20 a.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Annapolis

D. STREET ADDRESS (If rural, give location)

700 Americana Dr.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

4-22-1903

9. AGE (In years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

INVESTMENT COUNSLER

10B. KIND OF BUSINESS OR INDUSTRY

FINANCE

11. BIRTHPLACE (State or foreign country)

NEW YORK

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JAMES H. OTTLEY

14. MOTHER'S MAIDEN NAME

LUCETTA B. GILBERT

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

1940-1946

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MARGARET D. OTTLEY #2

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of head
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

700 Americana Drive

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
4 29 66 10:20p.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

shot self in head

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/30/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

CREMATION

23B. DATE

5-2-66

23C. NAME OF CEMETERY or CREMATORY

St. Lincoln

23D. LOCATION

(City, town, or county)

BLADENSBURG

(State)

MD.

24A. DATE REC'D BY HEALTH DEPT.

MAY 3 1966

24B. NAME OF REGISTRAR

John E. Taylor, M.D.

24C. FUNERAL DIRECTOR

John M. Taylor & Sons

ADDRESS

Annapolis, MD.

VALLEY FORGE

4-22-1908
J. H. K. K. K.
J. H. K. K. K.
J. H. K. K. K.

4-22-1908
J. H. K. K. K.
J. H. K. K. K.